



VIATICAL SETTLEMENT DOCUMENT CHECKLIST

To ensure that we can process your case quickly and provide you with the most complete feedback possible, please include all of the requested information and materials. Please check off the documents requested as you gather them and sign below when you have assembled a complete package. Call us toll-free at 1-888-874-2402 if you have any questions.

Application Questionnaire: FORM APP-MA QUEST

(Please note that there are two questionnaires – one for insured and one for owner.)

Representations, acknowledgements and warrants: FORM APP-MA QUEST REPS

___ signed by insured ___ signed by owner (if different from insured)

Disclosure Notice: FORM APP-MA DISCLOSURE

___ signed by insured ___ signed by owner

(if different from insured)

Medical Release: FORM APP-MA MED REL

___ signed by insured ___ notarized

HIPAA Disclosure: FORM APP-MA HIPAA

___ signed by insured ___ notarized

Life Insurance Policy Information Releases (there are two of these): FORM APP-MA INS REL

___ signed by owner ___ notarized

Photocopy of your Driver's License or other government-issued photo ID.

(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)

Photocopy of your Social Security card (or additional photo ID.)

(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)

Copy of your individual insurance policy (including the policy application)

Copy of your bankruptcy discharge papers

(if you have gone through a bankruptcy within the past 10 years)

Copy of your divorce decree and any documentation of settlement and/or custody arrangements

(if you have ever gone through a divorce)

If you have Group Life Insurance through your Employer or Membership Association:

A copy of your employee/member handbook/certificate explaining your group life benefits *

A copy of your group life insurance employee/member enrollment application *

A copy of your personal insurance certificate indicating the face amount of your coverage *

If on Disability Waiver of Premium, a copy of approval letter from the insurance company *

A copy of your latest pay statement indicating premiums withheld, if you pay premiums on your employer-sponsored insurance *

* If you do not have one or more of these items, please call us to discuss alternatives.

Initial _____ Date _____

Continued, please see next page.

FORM APP-MA DOCLIST



DOCUMENT CHECKLIST, Continued

If the owner or beneficiary is a trust, we need:

A copy of the trust document(s) and the Tax ID #. The Tax ID # is _____.

The trustee(s) to sign the Life Insurance Policy Information Release form(s).

If owner or beneficiary is a corporation, we need:

Complete name and address of corporation.

Corporate resolution showing current authorized officers.

Two corporate officers to sign the Life Insurance Policy Information Release form(s).

I certify that I have provided all of the above documents as indicated by my mark and that they are included within this packet I am returning to Habersham Funding LLC.

Signed _____ Date _____

FORM APP-MA DOCLIST



VIATICAL SETTLEMENT APPLICATION QUESTIONNAIRE

Information about the INSURED. Please see page 4 if you are the OWNER of the policy. Check here if the insured also is the owner of the policy:

The insured and the policy owner are the same person.

Full Legal Name: _____

Please list any aliases or nicknames: _____

DOB: ____/____/____ Male Female Height ____ Weight ____

Social Security # _____

Driver's License # & State: _____ Please provide photocopy of your license.

Street Address: _____

City: _____ State: _____ Zip: _____

May we leave a message? (Please circle at least one): Hm: _____(yes/no)

e-mail: _____ Wk: _____(yes/no)

Other #/cell _____(yes/no) Fax: _____(yes/no)

Have you ever been or are you now a party to a:

Bankruptcy? Yes ___ No ___ Civil suit? Yes ___ No ___ Divorce decree? Yes ___ No ___

Judgments? Yes ___ No ___ Tax lien? Yes ___ No ___ Creditor liens? Yes ___ No ___

EMPLOYMENT INFORMATION

Are you currently working? Yes ___ No ___ Are you retired? Yes ___ No ___

What is/was your occupation? _____

Are you receiving disability benefits? Yes ___ No ___ What kind? _____

Are you receiving (circle which applies): SSI Medicaid Food Stamps None of these

INSURANCE INFORMATION (please list additional policies on the following pages)

1st Policy:

Insurance Company Name: _____

Policy #: _____ Face Amount: _____ Effective Date: _____

Beneficiary(ies): _____

Premiums: \$ _____ per _____ (month, quarter, year, etc.)

Policy Type (circle one): **Group** **Group Conversion** **Individual**

If your policy is a group policy, please complete the following:

Employer Name: _____

Address & Phone: _____

FORM APP-MA QUEST

Building 11, Piedmont Center ■ 3495 Piedmont Road NE, Suite 910 ■ Atlanta, Georgia 30305
404-233-8275 ■ 888-874-2402 ■ Fax: 404-233-9394

Copyright 2005, Habersham Funding LLC

Page 1 of 6



APPLICATION QUESTIONNAIRE, Continued

Benefits Manager (for your employer): _____

May we contact this person in order to gather information about your policy? Yes ___ No ___

ADDITIONAL POLICIES:

2nd Policy:

Insurance Company Name: _____

Policy #: _____ Face Amount: _____ Effective Date: _____

Beneficiary(ies): _____

Premiums: \$ _____ per _____ (month, quarter, year, etc.)

Policy Type (circle one): Group Group Conversion Individual

3rd Policy:

Insurance Company Name: _____

Policy #: _____ Face Amount: _____ Effective Date: _____

Beneficiary(ies): _____

Premiums: \$ _____ per _____ (month, quarter, year, etc.)

Policy Type (circle one): Group Group Conversion Individual

Has an application for insurance on the insured's life/health ever been declined, rated or modified in any way (including this policy)? Yes ___ No ___ If yes, please describe the circumstances: _____

What is the total face value of life insurance on your life that is NOT being offered for sale here? _____

HEALTH INFORMATION

(please list additional physicians/medical providers on the following pages)

Please provide a brief description of your health condition (even if you consider yourself well/healthy):

What is your primary medical condition? _____

When was your primary medical condition first diagnosed? _____

What are your secondary medical conditions or health concerns? _____

When were these diagnosed? _____

Current/Primary Physician: _____

Address & Phone: _____

FORM APP-MA QUEST



APPLICATION QUESTIONNAIRE, Continued

Second Physician: _____

Address & Phone: _____

Third Physician: _____

Address & Phone: _____

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco? If so, please describe: _____

Has the insured used (now or ever before) alcoholic beverages? Yes ___ No ___ If yes, please answer:

Frequency: Daily ___ Weekly ___ Monthly ___ Occasionally ___

Average amount consumed each time insured drinks: 1-2 drinks 2-4 drinks 5 or more drinks

Has the insured ever undergone alcohol or other substance abuse treatment? If yes, please describe: _____

FAMILY HEALTH HISTORY

Table with 4 columns: Family Member, Age if living?, Deceased?, and If deceased, please list cause and age at time of death. Rows include Father, Mother, Brother, and Sister.

Please use a separate sheet of paper to list additional siblings.

Please INITIAL all that apply:

- List of statements for initialing: I have never been married, I am married, I am divorced, I am widowed, I have no children, I have minor children, One or more of my minor children are my legal dependents, I have no minor children.

FORM APP-MA QUEST



APPLICATION QUESTIONNAIRE, Continued

Information about the Life Insurance Policy OWNER. Please see page 1 if you are the INSURED. Check here if the owner is not an individual person (ie – a trust, corporation, etc.):

[] The owner is an entity or organization, not an individual.

Full Legal Name of Owner: _____

For trusts or corporations, please list the names of trustee(s) or 2 officers; please include their contact information below: _____

DOB: ___/___/___ Male [] Female []

Social Security # (or Tax ID #, for trust/corporation): _____

Driver's License # & State (if individual) : _____ Please provide photocopy.

Street Address: _____

City: _____ State: _____ Zip: _____

May we leave a message? (Please circle at least one): Hm: _____ (yes/no)

e-mail: _____ Wk: _____ (yes/no)

Other #/cell _____ (yes/no) Fax: _____ (yes/no)

Have you ever been or are you now a party to a:

Bankruptcy? Yes ___ No ___ Civil suit? Yes ___ No ___ Divorce decree? Yes ___ No ___

Judgments? Yes ___ No ___ Tax lien? Yes ___ No ___ Creditor liens? Yes ___ No ___

EMPLOYMENT INFORMATION (if individual)

Are you currently working? Yes ___ No ___ Are you retired? Yes ___ No ___

What is/was your occupation? _____

Are you receiving disability benefits? Yes ___ No ___ What kind? _____

Are you receiving (circle which applies): SSI Medicaid Food Stamps None of these

Please INITIAL all that apply (if individual):

- _____ I have never been married.
_____ I am married. My spouse's name is _____
_____ I am divorced. Attached is a complete copy of the dissolution of marriage, including any or all property and/or settlement orders.
_____ I am widowed.
_____ I have no children.
_____ I have minor children.
_____ One or more of my minor children are my legal dependents.
_____ I have no minor children. All of my children are of legal age.

FORM APP-MA QUEST



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

Insured and owner hereby represent, warrant, acknowledge and agree that: all the information contained herein or otherwise provided to Habersham Funding LLC is true, correct, complete, not misleading and can be relied upon; insured and owner will immediately notify Habersham Funding of changes in any of the information contained herein or provided elsewhere to Habersham Funding; Habersham Funding is authorized, but not obligated, to provide subject policy(ies) along with insured and/or owner's medical, financial and/or other personal information, to the organization(s) of its choice, in an effort to find a purchaser for such policy(ies); Habersham Funding purchases policies for its own account and for the accounts of other parties. Habersham Funding disclaims any duties, fiduciary or otherwise, to Applicant; no principal/agent relationship is created hereby.

Further, insured and owner hereby represent, warrant, acknowledge and agree that: the subject life insurance policy(ies) was legally obtained, and to the best of insured's and owner's knowledge, all of the information contained in the insurance application(s) for the subject life insurance policy(ies) is true, correct, complete and not misleading; if insured or owner knowingly present false or fraudulent information in an insurance or viatical application, then the insured and/or owner are guilty of a crime and may be subject to fines and confinement in prison; insured and owner understand that in some states, Habersham Funding may be required by law to report suspected insurance or viatical settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding may report all suspected insurance or viatical settlement fraud it discovers related to the subject life insurance policy(ies).

By the submission of this application to Habersham Funding, insured and owner hereby knowingly waive any and all claims they may have against Habersham Funding arising from Habersham Funding or any person to whom Habersham Funding presents said application reporting insured and owner for suspected insurance or viatical settlement fraud and agree to hold Habersham Funding harmless for any such report to law enforcement, regulatory or insurance company officials for suspected insurance or viatical settlement fraud whether or not it is ultimately determined that any such fraud was committed.

As insured and owner, I have signed the accompanying medical and policy information releases, and I will authorize any person or entity to release any information or documents required to verify my submissions or otherwise to complete any settlement transaction. Further, I hereby consent to the settlement transaction(s) herein described and acknowledge and represent that: (1) I am age eighteen (18) or older and am mentally competent; (2) that I in fact have a catastrophic, life-threatening, or chronic illness or condition; (3) I have a full and complete understanding of the Life Insurance Policy Purchase and Sale Agreement into which I am entering; and (4) that I am entering into such Agreement freely and voluntarily.

Signature of **insured**

Signature of policy **owner, if other than insured**

Printed name of insured

Printed name of owner

Date signed by insured

Date signed by owner

Must Be Notarized

Must Be Notarized

State of _____

State of _____

County of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Signature of Notary Public

Printed name of Notary Public

Printed name of Notary Public

My Commission Expires

My Commission Expires



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES
continued

I acknowledge that I have read and understand the contents of the Representations, Acknowledgements and Warrants.

Signature of **spouse of owner**, if the owner or spouse resides in a community property state (AZ, CA, ID, LA, NM, NV, PR, TX, WA and WI)

Printed name of spouse of owner

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

FORM APP-MA QUEST REPS



VIATICAL SETTLEMENT DISCLOSURES REQUIRED BY
THE MASSACHUSETTS ATTORNEY GENERAL'S
CONSUMER PROTECTION REGULATIONS

Business Name: Habersham Funding, LLC

Business or Mailing Address: Building 11, Piedmont Center, 3495 Piedmont Road NE, Suite 910, Atlanta, Georgia, 30305

Viatical Settlement Provider Massachusetts License Number: _____

Date License Issued: __/__/_____

License Expiration Date: _____

1. Habersham Funding, LLC (“we, us, our”) is a Viatical Settlement Provider. We shall not divulge Patient Identifying Information without the express, written consent of the Insured. We shall take every reasonable precaution to ensure that those individuals or entities who rightfully obtain Patient Identifying Information do not further divulge such information without the express, written consent of the Insured.
2. We shall provide the Insured with a copy of this completed disclosure form. We shall attempt to obtain the consent of the Insured prior to the dissemination of his/her Patient Identifying Information in connection with this Viatical Settlement.
3. As part of the Viatical Settlement, the health of the Insured will be monitored. We will obtain the Insured's consent to the following method of monitoring prior to the execution of the Viatical Settlement Contract. The Insured may be contacted by us, our agent or other authorized representative for the purpose of determining the Insured’s health status. This contact is limited to once every three (3) months if the Insured has a life expectancy of more than one (1) year, and no more than once per month if the Insured has a life expectancy of one (1) year or less.
4. You will not pay an application fee.
5. You will/will not pay a brokerage fee to Habersham Funding, LLC. Please contact your Viatical Settlement Broker to determine if you will be charged such a fee.
6. The Viatical Settlement proceeds shall be maintained in an escrow account until final payment is made to you. We will provide you with the name, address and telephone number of the escrow account agent who will maintain the proceeds pending execution of the Viatical Settlement within two business days of our identifying that escrow account agent.
7. Subject to the terms and conditions of the Viatical Settlement Contract, the proceeds will be sent to you within two (2) business days after we have received your insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the Viatical Settlement Contract.
8. If you have any questions about your legal rights, you should consult your own lawyer, especially before you sign any documents or pay any money or anything of value.

FORM APP-MA DISCLOSURE



9. DO NOT sign any application forms with blank spaces or with incorrect information.

PLEASE NOTE

10. You have the right to rescind on or before fifteen (15) calendar days (the "Rescission Period") from receipt of the Net Purchase Price. In order to rescind within the Rescission Period, you must provide written notice to us of your decision to rescind and you must return to us within the Rescission Period the full amount of the Purchase Price, plus premiums, loans, or other consideration, if any, paid by us during the Rescission Period. We will assign the Policy back to you immediately upon receipt of the Purchase Price. If you die during the Rescission Period, this Life Insurance Policy Purchase and Sale Agreement and the sale of your Policy shall be deemed rescinded, subject to repayment of the full amount of the Purchase Price if repaid within 90 days from the date of death of the Insured.
11. We shall not pay a finder's fee to any Person who is providing, or has previously provided, care or services to the Insured, including, but not limited to, any medical or mental health provider, social services provider, attorney, accountant, financial advisor or planner, investment advisor or planner, or any other Person who has a demonstrable conflict of interest in collecting a finder's fee.
12. Receipt of the proceeds of a Viatical Settlement may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should obtain advice from the appropriate government agencies regarding the impact such a settlement may have on your eligibility for such benefits before executing the Viatical Settlement Contract.
13. Some or all of the proceeds of the Viatical Settlement may be free from federal income tax and from state franchise and income taxes. You should obtain advice from a qualified professional tax advisor regarding the tax implications of entering into the Viatical Settlement Contract.
14. We meet the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners. We meet the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.
15. Entering into a Viatical Settlement Contract may cause other rights or benefits, including, but not limited to, conversion rights and waiver of premium benefits which may exist under the policy or certificate to be forfeited by you. You should seek assistance regarding the effect of entering into this Viatical Settlement from a qualified, independent financial advisor.
16. The proceeds of the Viatical Settlement may be subject to the claims of your creditors.
17. If you have any problems, please call us at: 1-888-874-2402.

FORM APP-MA DISCLOSURE



- 18. There are alternatives to the process of selling a Policy, which you may prefer. Some alternatives, where applicable, are (a) borrowing against the cash value of the Policy, (b) surrendering the Policy, and (c) accelerated death benefits that may be available under your Policy. You may obtain information on these alternatives directly from Insurer that issued your Policy.
- 19. In addition to the loss of coverage on Insured, Viator and Insured each acknowledge that if the Policy is a joint Policy, or contains riders or other provisions insuring the lives of a spouse, dependents or anyone other than Insured, there will be a loss of coverage on those additional insureds, and **Viator or Insured should contact Insurer or their insurance agent to determine if the coverage may be converted in order to avoid losing coverage.**
- 20. We agree that if the Policy contains a guaranteed insurability option, that the Viator retains all interests in and benefits from the exercise of such guaranteed insurability option. If the Viator exercises the guaranteed insurability option, and the Viator wishes to sell its rights thereunder, then we and Viator shall negotiate in good faith to determine the amount for which such rights will be sold.
- 21. There is no affiliation between Habersham Funding, LLC and the Insurer.
- 22. Viator understands that the amount payable to Viator's beneficiary(ies) upon the death of Insured, without the sale of the Policy pursuant to this Agreement, would be _____ (\$_____) and that the Purchase Price for the sale of the Policy pursuant to this Agreement is _____ (\$_____), and that the difference between the Purchase Price and the death benefit of the Policy is therefore _____ (\$_____). [If known] additional guaranteed benefits are _____, and the amount of accidental death and dismemberment benefits are _____. The Viator is selling and transferring all rights to these additional benefits to the Purchaser.
- 23. We do not set or determine compensation for any viatical settlement broker involved in this transaction, and such compensation is determined in the sole discretion of the viatical settlement broker. The viatical settlement broker is not affiliated with or an agent of us in this transaction. Under the law of certain states, the viatical settlement broker has statutorily defined duties to the viator of an insurance policy, and Viator and Insured acknowledge that they have been advised of this fact. **If you have questions about the compensation received by the viatical settlement broker in this transaction, you should contact your agent or the viatical settlement broker.**

I understand that any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a felony and may be subject to fines and confinement in prison.

I/We acknowledge that I/we have read and understand the contents of this disclosure.

Signature of **insured**

Signature of policy **owner, if other than insured**

Printed name of insured

Printed name of owner

Date signed by insured

Date signed by owner

Must Be Notarized

Must Be Notarized

State of _____

State of _____

County of _____

County of _____



Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Signature of Notary Public

Printed name of Notary Public

Printed name of Notary Public

My Commission Expires

My Commission Expires

Signature of **Habersham Funding, LLC**

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires _____

FORM APP-MA DISCLOSURE



AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize and request any physician, medical practitioner, medical facility, insurance company, medical information service, life expectancy estimating service or other institution or person having any records, charts, X-rays, laboratory work or other medical information in their possession or control to release such information to Habersham Funding LLC, its authorized personnel and its agents.

This request and release expressly includes all medical information, even information of a sensitive and confidential nature and **specifically including, but not limited to, records that may indicate the presence of mental illness, and any communicable disease or venereal disease, including but not limited to, hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS).**

Please treat any and all inquiries and requests made by Habersham Funding LLC, and its agents **as if made by me directly**. I agree that this authorization is valid for two years or for the maximum extent allowed by law from the date thereof, and that a photocopy or facsimile is as valid as an original. This release will be used to gather medical information to complete the evaluation, transfer, sale and/or resale of my life insurance policy; this release also may be used to gather medical information to track my on-going health status.

Signature of **insured**

Printed name of insured

Date signed by insured

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

FORM APP-MA MED REL



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliant)

The undersigned insured(s) (hereafter referred to as "I"), authorize the disclosure of my protected health information (PHI) as follows:

1. Classes of persons authorized to disclose my protected health information: I authorize each physician, doctor, physician practice group, nurse, hospital, and any other health care provider (each, an "Authorized Discloser") to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this authorization.
2. Person authorized to receive my protected health information: I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to Habersham Funding, LLC (Habersham Funding), [including its officers, employees, agents, independent contractors and authorized representatives (including but not limited to financing entities and life expectancy evaluation companies)] and to any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (collectively, the "Authorized Recipient"). I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site.
3. Description of protected health information authorized for disclosure and the purpose for such disclosure: This authorization shall apply to any and all of my health and medical records information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible purchase by the Authorized Recipient (and/or its funding entities) of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health medical status and condition in connection with any and all life insurance policies under which my life is insured that the Authorized Recipient purchases.
4. Expiration of authorization: This authorization shall remain valid until, and shall expire on, the date of my death, or for the maximum extent allowed by law from the date thereof.

Initial _____ Date _____

Continued, please see next page.

FORM APP-MA HIPAA



AUTHORIZATION OF RELEASE OF PHI
continued

5. Right to revoke authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that any revocation of this authorization shall not apply to the extent that (a) the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained or (b), if this authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and my PHI that is disclosed to the Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowingly presents false information in a life or viatical settlement application, contract or agreement is guilty of a felony and may be subject to fines and confinement in prison.

Signature of **insured**

Printed name of insured

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

FORM APP-MA HIPAA



AUTHORIZATION TO RELEASE LIFE INSURANCE POLICY INFORMATION

I hereby authorize _____, the issuer of Policy Number _____ and/or Certificate number _____ owned by _____ and insuring the life of _____, to release to Habersham Funding LLC, a copy of the application(s), policy, forms, riders or amendments of my policy. Further, I respectfully request and authorize that you send Habersham Funding LLC, any information they need pertaining to my policy, employment or health, including information that you would normally restrict to sending me, my physician, or the policy owner/insured.

Please treat any and all inquiries and requests made by Habersham Funding LLC, and its agents **as if made by me directly**. I agree that this authorization is valid for two years or for the maximum extent allowed by law from the date thereof, and that a photocopy or facsimile is as valid as an original. This release will be used to gather policy information to complete the evaluation, transfer, sale and/or resale of the policy.

Signature of policy **owner**

Printed name of owner

Date signed by owner

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

FORM APP-MA INS REL

THIS FORM MUST BE COMPLETED IN DUPLICATE



AUTHORIZATION TO RELEASE LIFE INSURANCE POLICY INFORMATION

I hereby authorize _____, the issuer of Policy Number _____ and/or Certificate number _____ owned by _____ and insuring the life of _____, to release to Habersham Funding LLC, a copy of the application(s), policy, forms, riders or amendments of my policy. Further, I respectfully request and authorize that you send Habersham Funding LLC, any information they need pertaining to my policy, employment or health, including information that you would normally restrict to sending me, my physician, or the policy owner/insured.

Please treat any and all inquiries and requests made by Habersham Funding LLC, and its agents **as if made by me directly**. I agree that this authorization is valid for two years or for the maximum extent allowed by law from the date thereof, and that a photocopy or facsimile is as valid as an original. This release will be used to gather policy information to complete the evaluation, transfer, sale and/or resale of the policy.

Signature of policy **owner**

Printed name of owner

Date signed by owner

Must Be Notarized

State of _____

County of _____

Subscribed, sworn to and acknowledged before me
this _____ day of _____, 20__.

Signature of Notary Public

Printed name of Notary Public

My Commission Expires

FORM APP-MA INS REL

THIS FORM MUST BE COMPLETED IN DUPLICATE