

SETTLEMENT APPLICATION PACKAGE

This application is for: a viatical settlement a life settlement
(Please check only one.)

Life settlements enable people who no longer want or need their life insurance – and *who do not have a catastrophic or life-threatening illness or condition* – to receive an advance cash payment for their policy. **Viatical settlements** provide that same option to people who do have a catastrophic or life-threatening illness or condition. *Please see our Disclosure Notice on Page 13 for a more detailed definition of viatical and life settlements.*

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*A few simple forms help us gather the information
we need to assist you*

- **Document Checklist** – This helps ensure we have all the information we need to serve you to the best of our abilities. We will not be able to proceed with your file until we have all of the listed items in hand and thoroughly completed.
- **Application** – If you have more than one life insurance policy, please complete the areas on the application for additional policies, or if you have more than one medical provider from whom we'll need to collect information, please provide complete information for each physician or other information source. *Please note that both the insured and the owner of the policy must complete separate sections of the application (unless the insured and the owner of the policy are the same person).*
- **Representations, acknowledgements and warranties** – Be sure to read thoroughly and sign the application, including this section.
- **Disclosure Notice & Maryland Viatical Settlement Brochure** – Information that is important to know if you are considering a viatical or life settlement. Notice must be signed and returned to us before an offer to purchase a policy can be made in Maryland.
- **Authorization to Release Medical Information** – We need your “okay” to access your medical records and other pertinent information about your current and ongoing health status.
- **Authorization for Disclosure of Protected Health Information** – In keeping with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA Privacy Regulations”), we need your HIPAA-compliant approval on this additional form (also used to access your medical records and other pertinent information).
- **Authorization to Release Life Insurance Policy Information** – Again, your permission is required to gather information about your life insurance policy(ies).

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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 (Pages 7-12)
(Please note that there are two questionnaires – one for insured and one for owner.)

Representations, acknowledgements and warranties (Page 11-12)
___ **signed by insured** ___ **signed by owner** (if different from insured)

Disclosure Notice (Pages 13-14) ___ **signed by insured** ___ **signed by owner**
(if different from insured)

Medical Release (Page 15) ___ **signed by insured** ___ **notarized**

HIPAA Disclosure (Pages 17-18) ___ **signed by insured** ___ **notarized**

Life Insurance Policy Information Releases (there are two of these) (Pages 21-23)
___ **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.



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 _____



APPLICATION QUESTIONNAIRE

Information about the INSURED. Please see page 10 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 ___

Judgment? Yes ___ No ___ Tax lien? Yes ___ No ___ Creditor lien? 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: _____



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: _____



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.



APPLICATION QUESTIONNAIRE, Continued

Information about the Life Insurance Policy OWNER. Please see page 7 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 ___

Judgment? Yes ___ No ___ Tax lien? Yes ___ No ___ Creditor lien? 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.



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; **insured or owner understand that any person who knowingly presents false information in an application for insurance or an application for viatical settlement contract has committed a fraudulent viatical settlement act and on conviction is subject to fines, imprisonment, or both, under § 27-408 of the Insurance Article of the Annotated Code of Maryland; insured and owner understand that in Maryland, Habersham Funding, is required by law to report suspected insurance, viatical or life settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding will report all suspected insurance, viatical or life 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, viatical or life settlement fraud and agree to hold Habersham Funding harmless for any such report to law enforcement, regulatory or insurance company officials for suspected insurance, viatical or life 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 am age eighteen or above and am mentally competent.

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

Subscribed, sworn to and acknowledged before me

This _____ day of _____, 20__.

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
FORM APP-AR

My Commission Expires

Revised 010705



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

continued

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

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



DISCLOSURE NOTICE: A NOTICE TO APPLICANTS

We at Habersham Funding, LLC, a viatical and life settlement company, do hereby advise you that:

- 1. There are alternatives to life settlement and viatical settlement contracts, which may include accelerated death benefits offered by the issuer of the policy, loans secured by the policy, and surrender of the policy for cash value. You should obtain information from your insurance company or your financial and legal advisors regarding the options available to you.
2. Some or all of the proceeds from a viatical or life settlement may be taxable under federal and state income tax law. You should seek assistance from your professional tax or financial advisor.
3. The proceeds of a viatical or life settlement may be subject to claims of creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.
4. A viatical or life settlement may adversely affect the viator's eligibility to Medicaid, supplemental social security income, public assistance and other government benefits and entitlements. You should obtain advice from the governmental organization responsible for providing these services.
5. You have the right to rescind the Life Insurance Policy Purchase and Sale Agreement for fifteen (15) calendar days after you receive the Net Purchase Price (the "Rescission Period"). In order to rescind, you must provide written notice to the Purchaser of your decision to rescind before the expiration of the Rescission Period. In order to rescind within the Rescission Period, you must return to Purchaser within the Rescission Period the full amount of the Net Purchase Price, plus premiums, loans, or other consideration, if any, paid by Purchaser during the Rescission Period. The Purchaser will assign the Policy back to you immediately upon receipt of the Net Purchase Price, plus the amounts noted above, if any. If you die during the Rescission Period, the Life Insurance Policy Purchase and Sale Agreement, and the sale of your Policy, subject to repayment of the full amount of the Net Purchase Price, as described above, shall be deemed rescinded.
6. The viatical settlement proceeds will be sent to you within three (3) business days after the purchaser confirms that all conditions precedent in the viatical settlement contract are satisfied, and acknowledgement of the transfer of the ownership (or interest in the certificate) from the insurer has been received and the beneficiary has been designated.
7. If the policy which is the subject of a viatical or life settlement is a joint policy, or contains riders or other provisions insuring the lives of a spouse, dependents, or anyone else other than the viator or life settlor, there may be a loss of coverage. You should consult your insurance producer or the issuer of the policy for advice.
8. Any person who knowingly presents false information in an application for insurance or an application for a viatical settlement contract has committed a fraudulent viatical settlement act and on conviction is subject to fines, imprisonment, or both, under § 27-408 of the Insurance Article of the Annotated Code of Maryland.
9. Entering into a viatical or life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the individual. You should seek assistance from your financial advisor.
10. A copy of the Maryland Insurance Administration's brochure entitled "Selling Your Life Insurance Policy: Understanding Viatical Settlements" describing the process of viatical settlements has been included with this application and should be read by an individual considering a life or viatical settlement.
11. All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.

Initial _____ Date _____

Continued, please see next page.



DISCLOSURE NOTICE: A NOTICE TO APPLICANTS
continued

- 12. You should contact your attorney, accountant, estate planner, financial planning advisor, insurer, insurance agent, tax advisor, or social services agency regarding potential consequences resulting from entering into a viatical or life settlement before you enter into a viatical settlement contract.
13. The insured may be contacted by the purchaser or its authorized representative or designees for the purpose of determining the insured's health status. This contact will be limited to once every three (3) months if the insured has a life expectancy of greater than one (1) year, and no more than one (1) time per month if the insured has a life expectancy of one (1) year or less.

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

State of

State of

County of

County of

Habersham Funding, LLC Date

State of

County of

A viatical settlement provider is required to disclose certain information to you before an offer to purchase your policy is made.

BEFORE YOU DECIDE

Before you agree to sell your policy:

- Make sure that your viatical settlement broker and viatical settlement provider are registered to conduct business in Maryland.
- Read and check all application forms for accuracy, especially information about your health history.
- Confirm your rights to change your mind about the viatical settlement after you get the proceeds, and how many days you have to return the money.
- Determine if you will lose public assistance benefits (food stamps, Medicaid, supplemental Social Security) or if your creditors could claim any part of your cash settlement.
- Make sure the viatical settlement provider agrees to put your settlement proceeds in escrow, either with an independent party or financial institution to ensure your funds are safe during the transfer.

- Determine if you still need life insurance protection.
- Understand the viatical settlement provider of your policy can periodically ask you about your health status.
- Know if you need permission to sell the policy, for instance is it a group policy.
- Understand how the amount of cash you get is determined and when you will receive payment. Get the agreed cash settlement figure in writing before settlement.

CHECK WITH THE STATE

Check the Maryland Insurance Administration's website at mdinsurance.state.md.us for information on the issues and risks of viatical settlements, or if you have concerns about viatical settlement provider offers to:

- Buy your life insurance policy, or assist you in buying an insurance policy as an investment.
- Buy your life insurance policy and you are in good health.
- Sell you a new life insurance policy and immediately sell it for cash.

This document is available in alternative format upon request from a qualified individual with a disability.

**SELLING YOUR LIFE
INSURANCE POLICY**

*Understanding
Viatical
Settlements*

Maryland Insurance Administration

525 St. Paul Place
Baltimore, Maryland 21202-2272
Phone 410-468-2000 or 1-800-492-5116
TTY 1-800-735-2258



Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lieutenant Governor

Alfred W. Redmer, Jr.
Insurance Commissioner

BROCHURE TTPS

The Maryland Insurance Administration and the National Association of Insurance Commissioners want you to have the facts before you enter into a *viatical settlement contract* to sell your life insurance policy. This brochure provides some of that information, but it is only a starting point.

You should also consult your own personal professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you and your family.

WHAT IS A VIATICAL SETTLEMENT?

A viatical settlement is the sale of a life insurance policy to a third party. The owner of the life insurance policy (*the viator*) sells the policy for an immediate cash benefit.

The buyer (*the viatical settlement provider*) becomes the new owner of the life insurance policy and receives all rights to and proceeds from the policy and also pays the premium. A viatical settlement provider must be registered with the State.

A *viatical settlement broker* is the person or company that on the viator's behalf and for a fee, commission or other valuable consideration, offers or attempts to negotiate a viatical settlement contract between a viator and one or more viatical settlement providers. In Maryland, a viatical settlement broker must be licensed to sell life insurance and also be registered with the State.

WHY SELL A LIFE INSURANCE POLICY?

At one time, most viators were people with a life-threatening illness. Now, individuals who are not facing a health crisis, including older people with a normal life expectancy, may sell their policies for cash. The most common reason for seniors to sell their policies is to address changes in their estate planning needs.

Viatical settlements have also become investment tools for companies and individuals. If you are asked about, or are considering the sale of your life insurance policy, or are interested in buying a life insurance policy as an investment, contact and consult with your personal professional advisor(s) before you make a decision.

Virtually any type of life insurance policy can be sold. Also, any portion of a policy can be sold with the remaining death benefit kept in the name of the original beneficiary.

CONSIDER ALL OF YOUR OPTIONS

If you're selling your policy to get cash to pay expenses, check all of your options first. It's likely you may have other ways of getting cash that is more appropriate for your situation and that enables you to keep your life insurance policy. Consult with your personal financial advisor, who knows your personal financial needs.

Find out if your life insurance policy has an accelerated death benefit, which typically pays a portion of the policy's face value, minus any outstanding policy loan, before the insured dies. This policy provision may be a way for you to get cash from a policy without selling it.

CONSUMER TTPS

When evaluating a viatical settlement contract, you should:

- Understand the process – decide whether to sell your policy directly to a viatical settlement provider, or use a viatical settlement broker for help.
- Comparison shop – get quotes from several companies to make sure you have a competitive offer.
- Check on the tax implications – all proceeds received from a viatical settlement may not be tax free.
- Understand the information needed by the viatical settlement provider – you should know who else may get your personal information.
- Know who will own the policy and whether it can be resold to another buyer.

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 (2) 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

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliant)

The undersigned insured (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 photostatic 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, [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 and 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.



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.

I understand that any person who knowingly presents false information in an application for insurance or an application for a viatical settlement contract has committed a fraudulent viatical settlement act and on conviction is subject to fines, imprisonment, or both, under § 27-408 of the Insurance Article of the Annotated Code of Maryland.

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

A NOTE ABOUT YOUR AUTHORIZATION(S) TO RELEASE LIFE INSURANCE POLICY INFORMATION

- Policy OWNER must **sign and have notarized** both attached copies of the Authorization to Release Life Insurance Policy Information.

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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

This page intentionally left blank.



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 (2) 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

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