

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 (*Completed and signed form MT-APP QUEST*)
(Please note that there are two questionnaires – one for insured and one for owner.)

® Disclosure Notice (*Signed form MT-APP DISCLOSURE*)
_____ **signed by insured** _____ **signed by owner** (if different from insured)

® Medical Release (*Signed form MT-APP MED REL*)
_____ **signed by insured** _____ **notarized**

® HIPAA Disclosure (*Signed form MT-APP HIPAA*)
_____ **signed by insured** _____ **notarized**

® Life Insurance Policy Information Release (*Form MT-APP INS REL completed in duplicate*)
_____ **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 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 a 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: _____



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

	Age if living?	Deceased?	If deceased, please list cause and age at time of death:
Father	_____	Yes ___ No ___	_____
Mother	_____	Yes ___ No ___	_____
Brother	_____	Yes ___ No ___	_____
Sister	_____	Yes ___ No ___	_____

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

Please INITIAL all that apply:

- _____ 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.



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 a 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.



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, viatical or life settlement 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, viatical or life settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding may 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 hereby consent to the settlement transaction(s) herein described and acknowledge and represent that: (1) I am eighteen or above and am mentally competent; (2) I have a full and complete understanding of the benefits of the Policy being sold and of the Life Insurance Policy Purchase and Sale Agreement into which I am entering; and (3) 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
MT-APP QUEST

My Commission Expires

Revised 121905



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTS

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

MONTANA DISCLOSURE FORM

You should carefully read the following points before you sign the Life Insurance Policy Purchase and Sale Agreement and seek additional advice where appropriate.

1. A Viatical Settlement Contract enables you to sell your Policy for cash at a discount from its face value, with the result of the loss of all death benefits, except double or additional indemnity benefits for accidental death, and the forfeiture of all other benefits, including conversion rights and waiver of premium benefits, payable to the current owner(s), beneficiary or beneficiaries, or the Insured(s). **You should obtain advice on these matters from your legal and financial advisors.**
2. 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.
3. Some or all of the proceeds from the sale of your Policy may be taxable under federal income tax and state franchise and income tax laws. **You should obtain advice on these matters from your legal, financial and tax advisors. Please note that neither a viatical settlement broker, a viatical settlement provider, nor their respective representatives, employees or agents may act as your personal tax advisor in this regard.**
4. The sale proceeds may be subject to claims by creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts. **You should obtain advice on these matters from your legal and financial advisors.**
5. Receipt of the sale proceeds may adversely affect your eligibility for Medicaid, Supplemental Social Security Income and any other means-based government programs, benefits or entitlement and may result in an interruption of such public assistance benefits. **You should obtain advice on these matters from appropriate agencies and from your legal and financial advisors.**
6. Entering into this Agreement may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the Policy, to be forfeited by you. **You should obtain advice on these matters from a financial advisor.**
7. Purchaser (identified below) may assign or otherwise transfer its interests in the Policy or the Viatical Settlement Contract to a third party after purchase from you.
8. The Net Purchase Price will be disbursed by the escrow agent designated in the Life Insurance Policy Purchase and Sale Agreement (“Escrow Agent”) to complete a proposed purchase of the Policy pursuant to the terms of the Escrow Agreement within three (3) business days after all of the following have occurred: (a) receipt by the Escrow Agent of fully-executed originals of all forms or written authorizations necessary to effect a change in both the beneficiary designation and the ownership of the Policy as contemplated by the Life Insurance Policy Purchase and Sale Agreement; (b) receipt by the Escrow Agent of an assignment by the applicable insurance company which accepts and recognizes Purchaser, its agents, designees or assigns, as the owner and beneficiary of the Policy; (c) verification by the Escrow Agent of other material information to verify the accuracy

MONTANA
DISCLOSURE FORM
continued

of the Policy as set forth in the Escrow Agreement; and (d) confirmation by the Purchaser that all closing conditions contained in the Life Insurance Purchase and Sale Agreement have been met. Purchaser's failure to disburse the Net Purchase Price within three (3) business days after satisfaction of the foregoing conditions shall render the viatical settlement contract void.

9. You may rescind a viatical settlement contract not later than thirty (30) calendar days after the contract is executed by all parties or fifteen (15) calendar days after receiving the viatical settlement proceeds, whichever is the longer period (the "Rescission Period"). In order to rescind within the Rescission Period, you must provide written notice to the Purchaser of your decision to rescind and you must return to Purchaser within the Rescission Period the full amount of the Purchase Price, plus premiums, loans, or other consideration, if any, paid by Purchaser during the Rescission Period. Purchaser will assign the Policy back to you immediately upon receipt of the Purchase Price. 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 Purchase Price, as described in the Life Insurance Policy Purchase and Sale Agreement, shall be deemed rescinded.
10. The Insured may be contacted by the Purchaser, its agent or other authorized representative for the purpose of determining the Insured's health status. Such contact will be limited to once every three (3) months if the Insured has a life expectancy of more than one (1) year at the time the Life Insurance Policy Purchase and Sale Agreement is entered into, and to no more than once per month if the Insured has a life expectancy of one (1) year or less. Unless Insured designates a contact under the Life Insurance Policy Purchase and Sale Agreement, Insured agrees that Purchaser may contact Insured as described in this paragraph. If Insured desires, Insured may designate any individual of legal age, who is in regular contact with Insured as a contact for inquiries about Insured's health or medical status ("Insured's Designee"). Insured shall provide the name, address, telephone number and relationship of Insured's Designee, and may change Insured's Designee by delivering written notice of such change to Purchaser.
11. 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.**
12. There is no affiliation between the Purchaser and the Insurer.
13. The Purchaser is Habersham Funding, LLC; a licensed viatical settlement provider located at 415 East Paces Ferry Road, Terrace Level, Atlanta, Georgia, 30305. Tel: 404-233-8275.
14. All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about a viator or an insured, including the viator's and insured's identity or the identity of family members is confidential. Such information may not be disclosed in any form to any person unless disclosure: (a) is necessary to affect the viatical settlement between the viator and the viatical settlement provider; and (b) the viator of the insured, as the case may be,

MONTANA
DISCLOSURE FORM
continued

has provided written 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.

15. The Viator and Insured acknowledge that they received a copy of the NAIC's form describing the process of viatical settlements.
16. The Purchaser does 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 the Purchaser 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.**
17. 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 _____

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. This authorization may be revoked by me at any time upon my written notice to HABERSHAM FUNDING, LLC at the address provided below.

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

**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 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 (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)

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 the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

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 viatical or life settlement application, contract or agreement is guilty of a crime 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



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. This authorization may be revoked by me at any time upon my written notice to HABERSHAM FUNDING, LLC at the address provided below.

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 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. This authorization may be revoked by me at any time upon my written notice to HABERSHAM FUNDING, LLC at the address provided below.

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 FORM MUST BE COMPLETED IN DUPLICATE