

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** – information that is important to know if you are considering a viatical or life settlement.
- **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: NA

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: NA

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: NA

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 ___

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 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 ___

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 may be guilty of a crime and subject to prosecution; insured and owner understand that in some states, 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
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 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



HABERSHAM FUNDING, LLC
DISCLOSURE FORM

IMPORTANT—READ THIS DISCLOSURE FORM BEFORE
SIGNING THE LIFE INSURANCE POLICY PURCHASE AND SALE
AGREEMENT.

VIATICATING YOUR LIFE INSURANCE POLICY?

"You" or "Your" as used in this disclosure form, refers to the owner of the life insurance policy, which may or may not be the person who is insured under the policy.

Are you thinking about viaticating your life insurance policy? If you are, your decision could be a good one --or a mistake. You will not know for sure unless you carefully consider all of the options available to you and the consequences of viaticating your life insurance policy.

We are required to inform you of the following:

1. Make sure you understand the facts. You should ask your insurance company to review all the possible alternatives that your life insurance policy may offer in lieu of a viatical settlement, including any accelerated death benefits or policy loans offered under your life insurance policy.
2. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income tax laws. **You should seek assistance from a professional tax advisor.**
3. The proceeds from a viatical settlement may be subject to the claims of 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.**
4. Proceeds from a viatical settlement may adversely affect your eligibility for Medicaid or other medical assistance, government benefits, or entitlements. **You should seek advice from the appropriate government agencies.**
5. You have the unconditional 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.
6. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded subject to repayment of all viatical settlement proceeds, including any commissions, premiums, loans, and loan interest paid on behalf of the viator from proceeds due the viator to the viatical settlement provider or viatical settlement purchaser.
7. The Net Purchase Price will be disbursed by the Escrow Agent to complete a purchase of the Policy pursuant to the terms of the Escrow Agreement within three business days (3) after all of the following have occurred: (a) receipt by the Escrow Agent of the originals of fully executed copies of all forms or written

DISCLOSURE FORM

continued

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; and (c) verification by the Escrow Agent of material information, including (i) the face amount of, and death benefit payable under, the Policy; (ii) all encumbrances on the Policy known to the Insurer, including loans, loan interest, collateral assignments or other liens such as a divorce-related decrees; (iii) verify current owner and beneficiary of record of the Policy; (iv) the next premium due date; (v) the absence of any due but unpaid premiums on the Policy; (vi) that the Policy is in effect and has not lapsed; (vii) the Policy is beyond its contestability and suicide period, and (viii) all closing conditions in the Life Insurance Policy Purchase and Sale Agreement have been satisfied. Escrow Agent shall provide written confirmation of this information to Purchaser in the form of a certificate signed by a duly authorized representative of Escrow Agent.

8. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under your policy or certificate, to be forfeited. **Assistance should be sought from a financial advisor.**
9. A Life Insurance Policy Purchase and Sale Agreement enables you to sell your life insurance policy for cash at a discount from its face value, with the result of the loss of all death benefits and all other benefits payable to the current Owners, beneficiary or beneficiaries, or the Insured.
10. 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.**
11. Purchaser may assign or otherwise transfer its interests in the Policy or the Life Insurance Policy Purchase and Sale Agreement to a third party after purchase from you.
12. Purchaser will be the new policyholder or certificate holder pursuant to the Life Insurance Policy Purchase and Sale Agreement.
13. Viator understands that the Purchaser is Habersham Funding, LLC, located at Building 11, Piedmont Center, 3495 Piedmont Road NE, Suite 910, Atlanta, Georgia 30305. Telephone: 888-874-2402.
14. Viator understands that the Escrow Agent is _____, located at _____ . Telephone: _____. A copy of the Escrow Agreement is attached as Exhibit L to the Life Insurance Policy Purchase and Sale Agreement.
15. There is no affiliation between the Purchaser and the Insurer.
16. 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.

DISCLOSURE FORM

continued

17. The death benefit payable to the Purchaser or its designee, assignee or successor as result of this transaction is _____. Additional benefits available under the Policy [list any known benefits]. Purchaser has purchased all of these benefits from you, and will receive any such benefits as become payable.

18. Viator understands that he or she may receive copies of the relevant escrow documents by contacting the escrow agent identified in Section 1.6 of the Life Insurance Policy Purchase and Sale.

19. 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 financial, legal or insurance advisors, or the viatical settlement broker.**

Privacy Considerations

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.

If you are the insured, both the viatical settlement provider and the viatical settlement broker may contact you to determine your health status. This contact is limited, in the aggregate, to once every three months if your life expectancy is more than one year, and no more than once per month if your life expectancy is one year or less. There are no limitations on contacts for purposes other than to determine the insured's health status.

Your Viatical Settlement Broker

A viatical settlement broker is a person who on behalf of another and for a fee, commission, or other valuable consideration introduces viators to viatical settlement providers, or offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers.

Your viatical settlement broker can represent multiple parties in this transaction. He can represent you, a viatical settlement provider, or another third party. He cannot represent your insurance company when he is discussing viatical settlements.

If you want the viatical settlement broker to act exclusively for you, you and the viatical settlement broker should execute a separate written agreement in which the viatical settlement broker (i) discloses fully all his interests in the viatical settlement contract and his relationships with the viatical settlement provider, including the viatical settlement provider's affiliates and appointed or contracted agents, and (ii) agrees that



DISCLOSURE FORM

continued

compensation for his services as a viatical settlement broker shall be paid directly and only by you.

Review all options and issues before you decide. This way you can be sure you are making a decision that is in your best interest.

Viatical settlement transactions between a viatical settlement broker or viatical settlement provider and a resident of this Commonwealth who is a viator or insured are subject to regulation by the State Corporation Commission acting through the Bureau of Insurance pursuant to provisions comprising Chapter 60 (§ 38.2-6000 et seq.) of Title 38.2 of the Code of Virginia. Any person damaged by the acts of a person in violation of this chapter may bring a civil action in a court of competent jurisdiction against the person committing the violations.

I understand that any person who knowingly presents false information in an application for insurance or a viatical settlement contract or life settlement purchase agreement may be guilty of a crime and subject to prosecution.

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

Habersham Funding, LLC

Date

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. I have retained a copy of this signed authorization for future reference.

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(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.

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 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

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. I have retained a copy of this signed authorization for future reference.

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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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. I have retained a copy of this signed authorization for future reference.

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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