

## 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 APP-KS QUEST  
(Please note that there are two questionnaires – one for insured and one for owner.)
- Representations, acknowledgements and warrants APP-KS QUEST  
\_\_\_\_\_ **signed by insured** \_\_\_\_\_ **signed by owner** (if different from insured)
- Disclosure Notice APP-KS DISCLOSURE \_\_\_\_\_ **signed by insured** \_\_\_\_\_ **signed by owner**  
(if different from insured)
- Medical Release APP-KS MED REL \_\_\_\_\_ **signed by insured** \_\_\_\_\_ **notarized**
- HIPAA Disclosure APP-KS HIPAA \_\_\_\_\_ **signed by insured** \_\_\_\_\_ **notarized**
- Life Insurance Policy Information Releases (there are two of these) APP-KS INS REL  
\_\_\_\_\_ **signed by owner** \_\_\_\_\_ **notarized**
- Photocopy of your Driver's License or other government-issued photo ID.  
(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)
- Photocopy of your Social Security card (or additional photo ID.)  
(If the policy OWNER and the INSURED are different, we need copies of identification for BOTH persons.)
- Copy of your individual insurance policy (*including the policy application*)
- Copy of your bankruptcy discharge papers  
(if you have gone through a bankruptcy within the past 10 years)
- Copy of your divorce decree and any documentation of settlement and/or custody arrangements  
(if you have ever gone through a divorce)

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

- A copy of your employee/member handbook/certificate explaining your group life benefits \*
- A copy of your group life insurance employee/member enrollment application \*
- A copy of your personal insurance certificate indicating the face amount of your coverage \*
- If on Disability Waiver of Premium, a copy of approval letter from the insurance company \*
- A copy of your latest pay statement indicating premiums withheld, if you pay premiums on your employer-sponsored insurance \*

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

Initial \_\_\_\_\_ Date \_\_\_\_\_

*Continued, please see next page.*



## 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 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:

2<sup>nd</sup> 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

3<sup>rd</sup> 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 1 if you are the INSURED. Check here if the owner is not an individual person (ie – a trust, corporation, etc.):

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

Full Legal Name of Owner: \_\_\_\_\_

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

DOB: \_\_\_/\_\_\_/\_\_\_ Male [ ] Female [ ]

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

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

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

e-mail: \_\_\_\_\_ Wk: \_\_\_\_\_ (yes/no)

Other #/cell \_\_\_\_\_ (yes/no) Fax: \_\_\_\_\_ (yes/no)

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

Bankruptcy? Yes \_\_\_ No \_\_\_ Civil suit? Yes \_\_\_ No \_\_\_ Divorce decree? Yes \_\_\_ No \_\_\_

Judgments? Yes \_\_\_ No \_\_\_ Tax lien? Yes \_\_\_ No \_\_\_ Creditor liens? Yes \_\_\_ No \_\_\_

EMPLOYMENT INFORMATION (if individual)

Are you currently working? Yes \_\_\_ No \_\_\_ Are you retired? Yes \_\_\_ No \_\_\_

What is/was your occupation? \_\_\_\_\_

Are you receiving disability benefits? Yes \_\_\_ No \_\_\_ What kind? \_\_\_\_\_

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

Please INITIAL all that apply (if individual):

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



APPLICATION QUESTIONNAIRE, Continued

Information about the VIATICAL SETTLEMENT PRODUCER. Please provide the identity of any person or organization that served as a viatical settlement producer in connection with this settlement transaction.

Name of Producer: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

\_\_\_\_\_

Name of Producer: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

\_\_\_\_\_

Name of Producer: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

\_\_\_\_\_

Name of Producer: \_\_\_\_\_

Address & Phone: \_\_\_\_\_

\_\_\_\_\_



## REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTS

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 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 hereby consent to the settlement transaction(s) herein described and acknowledge and represent that: (1) I am age eighteen (18) or older and am mentally competent; (2) if this is a viatical settlement, that I in fact have a catastrophic or life-threatening, illness or condition; (3) I have a full and complete understanding of the Life Insurance Policy Purchase and Sale Agreement into which I am entering and of the benefits of the Policy being sold; and (4) that I am entering into such Agreement freely and voluntarily.

\_\_\_\_\_  
Signature of **insured**

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

\_\_\_\_\_  
Printed name of insured

\_\_\_\_\_  
Printed name of owner

\_\_\_\_\_  
Date signed by insured

\_\_\_\_\_  
Date signed by owner

**Must Be Notarized**

**Must Be Notarized**

State of \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Subscribed, sworn to and acknowledged before me  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires  
APP-KS QUEST

\_\_\_\_\_  
My Commission Expires

Revised 093008



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



## DISCLOSURE NOTICE: A NOTICE TO APPLICANTS

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

1. Individuals wishing to sell their policies may have alternatives to viatical or life settlements. These alternatives may include accelerated 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 advisors regarding the options available to you.
2. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.
3. Receipt of the proceeds of a viatical or life settlement may affect an individual's ability to receive supplemental social security income, public assistance and public medical services, including Medicaid, or other governmental benefits or entitlements. You should consult the governmental organization responsible for providing these services.
4. The proceeds of a viatical or life settlement could be subject to the claims of creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.
5. In connection with this application, you will receive a brochure explaining how viatical settlements work.
6. One consequence of selling your insurance policy will be the loss of some or all of the death benefit payable to the current beneficiary(ies).
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 possible loss of coverage.
8. Entering into a viatical or life settlement contract will have an effect on payment of premiums and dispositions of proceeds, cash values, and dividends, and 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.
9. Proceeds from the sale of your policy will be sent to you within three (3) business days after we have confirmed that all conditions contained in the life insurance purchase and sale agreement have been met, and we have received a valid and effective acknowledgement from the insurance company acknowledging that the owner and beneficiary of your policy have been transferred.
10. You acknowledge that you have received a copy of the NAIC's brochure describing the process of viatical settlements.
11. You have the right to rescind on or before fifteen (15) calendar days (the "Rescission Period") from receipt of the viatical settlement proceeds. In order to rescind within the Rescission Period, you must provide written notice to us of your decision to rescind and you must return to us within the Rescission Period the full amount of the settlement proceeds, plus premiums, loans, or other consideration, if any, paid by us during the Rescission Period. We will assign the policy back to you immediately upon receipt of the full amount of the viatical settlement proceeds. If you die during the Rescission Period, subject to repayment of all sums noted in this section, your viatical settlement contract shall be deemed to be rescinded.
12. The insured person under the policy may be contacted by us, our agent or other authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

APP-KS DISCLOSURE

Revised 093008

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

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Page 1 of 3

13. All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including Insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the sale of the Policy by Viator to the Purchaser. 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.
14. If a viatical settlement broker will be involved in this transaction, that broker represents exclusively the viator and not the insurer or the viatical settlement provider. Furthermore, the viatical settlement broker owes a fiduciary duty to the viator including the duty to act according to the viator's instructions and in the best interest of the viator.
15. You should contact an attorney, accountant, estate planner, financial planning advisor, the insurer, insurance agent, tax advisor, or social services agency regarding potential consequences resulting from entering into a viatical or life settlement.

**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.

\_\_\_\_\_  
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 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 or viatical settlement application, contract or agreement is guilty of a felony and may be subject to fines and confinement in prison.

Signature of insured

Printed name of insured

Must Be Notarized

State of

County of

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

Signature of Notary Public

Printed name of Notary Public

My Commission Expires



## 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 FORM MUST BE COMPLETED IN DUPLICATE**



AUTHORIZATION TO RELEASE LIFE INSURANCE POLICY INFORMATION

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

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

\_\_\_\_\_  
Signature of policy owner

\_\_\_\_\_  
Printed name of owner

\_\_\_\_\_  
Date signed by owner

Must Be Notarized

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to and acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed name of Notary Public

\_\_\_\_\_  
My Commission Expires

THIS FORM MUST BE COMPLETED IN DUPLICATE