

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.

*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).

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 (Please note that there are two questionnaires – one for insured and one for owner.)
- Representations, acknowledgements and warranties
_____ **signed by insured** _____ **signed by owner** (if different from insured)
- Disclosure Notice _____ **signed by insured** _____ **signed by owner** (if different from insured)
- Medical Release _____ **signed by insured** _____ **notarized**
- HIPAA Disclosure _____ **signed by insured** _____ **notarized**
- Life Insurance Policy Information Releases
_____ **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 8 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

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 5 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 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 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 NOTICE:
A NOTICE TO APPLICANTS

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

(a) **Potential Purchaser:** The potential Purchaser is Habersham Funding, LLC, located at Building 11, Piedmont Center, 3495 Piedmont Road NE, Suite 910, Atlanta, Georgia 30305, phone: 404-233-8275.

(b) **Joint Policy:** If the Policy has been issued as a joint policy or involves family riders or any coverage of a life other than the Insured, there is a possible loss of coverage on the other lives under the Policy and advice should be sought from the Viator's insurance agent or the Insurer.

(c) **Death Benefit Payable to Purchaser:** The dollar amount of the current death benefit payable to the Purchaser under the Policy is [«Death_Benefit__Amount»], and, [if known,] the availability of any additional guaranteed insurance benefits, [«Dollar_Amount_of_Death_Benefit»] the dollar amount of any accidental death and dismemberment benefits under the Policy [«Dollar_Amount_of_Death_Benefit»], and all of the Viator's interest in those benefits will be transferred as a result of this Agreement.

(d) **Alternatives to Viatical or Life Settlement:** There are possible alternatives to the sale of your Policy pursuant to a viatical settlement contract, including any accelerated death benefits offered under the Policy.

(e) **Tax Liability:** Some or all of the settlement proceeds resulting from a sale of the Policy may be subject to federal income taxation and state franchise and income taxation, including estate taxes, and you should seek assistance from a professional tax advisor, such as a certified public accountant or an Ohio-licensed attorney.

(f) **Claims of Creditors:** The settlement proceeds you will receive if you sell your Policy could be subject to the claims of creditors.

(g) **Eligibility for Medicaid or Other Government Programs:** The receipt of the proceeds of the viatical settlement may adversely affect the Viator's eligibility for medical assistance under Chapter 5111. of the Ohio Revised Code (Medicaid) or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

(h) **Viator's Right to Rescind Viatical Settlement Contract:** The Viator has a right to rescind a viatical settlement contract for *fifteen* calendar days after the Viator receives the settlement proceeds, as provided in section 3916.08 of the Ohio Revised Code. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment of the settlement proceeds to the Purchaser.

(i) **Transfer of Settlement Funds :** The settlement proceeds will be sent to the Viator within *three* business days after the Purchaser has received written acknowledgment from the Insurer or group administrator that ownership of the Policy or interest in the certificate has been transferred and that the beneficiary has been designated pursuant to this Agreement.

(j) **Other Contract Rights Under the Insurance Policy:** Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the Policy to be forfeited by the Viator and at assistance should be sought from a financial advisor. Selling the Policy means all rights to the Policy are transferred.

(k) **Contacts with the Insured:** Following execution of the viatical settlement contract, the Purchaser, or the authorized representative of the Purchaser may contact the insured for the purpose of determining the Insured's health status and to confirm the Insured's residential or business address and telephone number or for other purposes permitted by law. Any such contact shall be limited to once in any three-month period if the Insured has a life expectancy of more than one year or to once per month if the Insured has a life expectancy of one year or less.

Building 11, Piedmont Center ■ 3495 Piedmont Road NE, Suite 910 ■ Atlanta, Georgia 30305-3306
404-233-8275 ■ 888-874-2402 ■ Fax: 404-233-9394

(l) Disclosure of Medical, Financial or Personal Information:

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."

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

Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and imprisonment.

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

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I

I, the undersigned, hereby authorize any physician, medical practitioner, hospital or medical related facility, insurance company, the Medical Information Bureau, life expectancy estimating company, «Name_of_Insurance_Company», or other institution or person(s) having any records, charts, X-rays, laboratory work or similar information regarding my health, including, but not limited to, information relating to AIDS, ARC, HIV, heart disease, cancer, alcohol and/or drug abuse, mental illness, communicable diseases and any life threatening or terminal conditions to release such information to HABERSHAM FUNDING, LLC, or the Insurer and their authorized representatives and/or their successors, assignees and designees. I hereby consent and agree to the release of any and all medical records, which may be requested by HABERSHAM FUNDING, LLC, or the Insurer and their authorized representatives and/or their successors, assignees and designees that are required to complete the evaluation, transfer, sale and/or resale of life insurance policy # «Policy_Number», insured by «Name_of_Insurance_Company» ("Policy"). I understand that information obtained may be used to evaluate the Policy for possible sale to HABERSHAM FUNDING, LLC or its successors, assignees and designees, and over the course of time to re-evaluate my life expectancy. I understand that this information will be used to establish my life expectancy now and in the future. I agree that this authorization is valid for the maximum extent allowed by law from the date hereof, and that a photocopy or facsimile of it is as valid as the original. I acknowledge and agree that this Authorization to Release Medical Information may be used to monitor my on-going health status. This is durable document meant to survive regardless of my future mental condition and is meant to remain in force following my death.

«Name_of_Insured_1»

NOTARY

State of _____
County of _____

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

Notary Public
My commission expires: _____

(NOTARIAL SEAL)

INSURED'S AUTHORIZATION TO RELEASE MEDICAL 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 of 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, and its employees, representatives, designees, agents, successors or assigns, 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, including HIV and AIDS-related information, drug and alcohol-related patient records and mental health-related records, 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. Further Disclosure: Some of the PHI has been disclosed to you from records protected by federal confidentiality rules or from confidential records protected by state law. These laws generally prohibit the further disclosure of drug-related or HIV-related information without specific written consent. I acknowledge these laws and expressly authorize each Authorized Recipient of my information to further disclose the information to the extent such further disclosure is necessary in order to carry out the purposes of the original disclosure.
5. 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.
6. 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; provide, 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 (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

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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.

«Name_of_Insured_1»

Must Be Notarized

NOTARY

State of _____
County of _____

Subscribed and affirmed to before me this ____
day of _____, 20__.

Notary Public
My commission expires: _____

(NOTARIAL SEAL)

**AUTHORIZATION TO RELEASE
LIFE INSURANCE POLICY INFORMATION**

The undersigned hereby authorizes the «Name_of_Insurance_Company», the issuer of Policy Number and/or Certificate Number «Policy_Number» insuring the life of «Name_of_Insured_1» (the "Policy") and/or its agents and any other entity or person that has information related thereto, to release to HABERSHAM FUNDING, LLC, or any of its authorized representatives, and/or its successors, assignees, and designees, a copy of the policy, applications, forms, riders, amendments or any other documents, data or information related thereto, of the Policy. The undersigned respectfully requests that you reply immediately to any written, telephonic or other request for information or documents required by HABERSHAM FUNDING, LLC, or its authorized representatives, and/or its successors, assignees, and designees, pertaining to the above-referenced policy.

The undersigned agrees that this Release is irrevocable and shall remain valid and in force for the maximum period of time permitted by law. The undersigned agrees that a photocopy or facsimile of this Release is as valid as an original. The undersigned understands that this Release will be used to gather information about the above-reference policy to conduct and complete the evaluation, transfer, assignment, sale and/or resale of the above-referenced policy.

«Name_of_Insured_1»

Date _____

NOTARY

State of _____

County of _____

Subscribed and affirmed to before me this ____
day of _____, 20__.

Notary Public
My commission expires: _____

(NOTARIAL SEAL)