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 warrants
_____ **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** _____ **signed by owner**

HIPAA Disclosure _____ **signed by insured** _____ **signed by owner**

Life Insurance Policy Information Releases (there are two of these)

Viator's and Insured's Release – Disclosure of Information
_____ **signed by insured** _____ **signed by owner** (if different from insured)

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.

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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 _________________________

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APPLICATION QUESTIONNAIRE

Information about the INSURED. Please see page 6 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 c*ircle 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:____

____

FORM APP-IN QUEST Revised 120105

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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:______________________________

____

FORM APP-IN QUEST Revised 120105

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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.

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APPLICATION QUESTIONNAIRE, Continued

Information about the Life Insurance Policy OWNER. Please see page 3 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 c*ircle 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.

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APPLICATION QUESTIONNAIRE, Continued

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

Name of Broker: ____________________

Address & Phone: ____________________

____

____

Name of Broker: ____________________

Address & Phone: ____________________

____

____

Name of Broker: ____________________

Address & Phone: ____________________

____

____

Name of Broker: ____________________

Address & Phone: ____________________

____

____

FORM APP-IN QUEST Revised 120105

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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 may be required by law to report suspected insurance, viatical or life settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding may report all suspected insurance, viatical or life settlement fraud it discovers related to the subject life insurance policy(ies).

By the submission of this application to Habersham Funding, insured and owner hereby knowingly waive any and all claims they may have against Habersham Funding arising from Habersham Funding or any person to whom Habersham Funding presents said application reporting insured and owner for suspected insurance, viatical or life settlement fraud and agree to hold Habersham Funding harmless for any such report to law enforcement, regulatory or insurance company officials for suspected insurance, viatical or life settlement fraud whether or not it is ultimately determined that any such fraud was committed.

As insured and owner, I have signed the accompanying medical and policy information releases, and I will authorize any person or entity to release any information or documents required to verify my submissions or otherwise to complete any settlement transaction. Further, I hereby consent to the settlement transaction(s) herein described and acknowledge and represent that: (1) I am 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	Subscribed, sworn to and acknowledged before me
this ________ day of _________________, 20__.	this ________ day of _________________, 20__.
______________________________	______________________________
Signature of Notary Public	Signature of Notary Public
______________________________	______________________________
Printed name of Notary Public	Printed name of Notary Public
______________________________	______________________________
My Commission Expires	My Commission Expires

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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

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INDIANA
DISCLOSURE FORM

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

1. Your Policy provides financial protection to your beneficiaries. If you sell your Policy to us, your beneficiaries will no longer have that protection. Before you sell your policy, you should consider whether that protection is needed. Other financial options may be available to you. **Consult your financial advisor or insurance company for more information.**
2. There are alternatives to the process of selling a Policy, which you may prefer. Some alternatives, where applicable, are (a) borrowing against the cash value of the Policy, (b) surrendering the Policy for its cash value or exercising other nonforfeiture options available under the Policy, and (c) accelerated death benefits that may be available under your Policy. You may obtain information on these alternatives directly from Insurer that issued your Policy.
3. Some or all of the proceeds from the sale of your Policy may be taxable under federal income tax and state franchise and income tax laws. **You should obtain advice on these matters from your legal, financial and tax advisors.**
4. The sale proceeds may be subject to claims by creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts. **You should obtain advice on these matters from your legal and financial advisors.**
5. Receipt of the sale proceeds may adversely affect your eligibility for Medicaid, Supplemental Social Security Income and any other means-based government programs, benefits or entitlement and may result in an interruption of such public assistance benefits. **You should obtain advice on these matters from appropriate agencies and from your legal and financial advisors.**
6. Entering into this Agreement may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the Policy, to be forfeited by you. **You should obtain advice on these matters from a financial advisor.**
7. Purchaser (identified below) may assign or otherwise transfer its interests in the Policy or the Viatical or Life Settlement Contract to a third party after purchase from you.
8. The Net Purchase Price will be disbursed by the escrow agent designated in the Life Insurance Policy Purchase and Sale Agreement ("Escrow Agent") to complete a proposed purchase of the Policy pursuant to the terms of the Escrow Agreement within two (2) business days after all of the following have occurred: (a) receipt by the Escrow Agent of fully-executed originals of all forms or written authorizations necessary to effect a change in both the beneficiary designation and the ownership of the Policy as contemplated by the Life Insurance Policy Purchase and Sale Agreement; (b) receipt by the Escrow Agent of an assignment by the applicable insurance company which accepts and recognizes Purchaser, its agents, designees or assigns, as the owner and beneficiary of the Policy; (c) verification by the Escrow Agent of other material information to verify the accuracy of the Policy as set forth in the Escrow Agreement; and (d) confirmation by the Purchaser that all closing conditions contained in the Life Insurance Purchase and Sale Agreement have been met.

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9. You may rescind a viatical or life settlement contract within thirty (30) calendar days after the contract is executed by all parties or fifteen (15) calendar days after receiving the settlement proceeds, whichever is later (the "Rescission Period"). In order to rescind within the Rescission Period, you must provide written notice to the Purchaser of your decision to rescind and you must return to Purchaser within the Rescission Period the full amount of the Purchase Price, plus premiums, loans, or other consideration, if any, paid by Purchaser during the Rescission Period. Purchaser will assign the Policy back to you immediately upon receipt of the Purchase Price. If you die during the Rescission Period, the Life Insurance Policy Purchase and Sale Agreement, and the sale of your Policy, subject to repayment of the full amount of the Purchase Price, as described in the Life Insurance Policy Purchase and Sale Agreement, shall be deemed rescinded.

10. The Insured may be contacted by the Purchaser, its agent or other authorized representative for the purpose of determining the Insured's health status. Such contact will be limited to once every three (3) months if the Insured has a life expectancy of more than one (1) year at the time the Life Insurance Policy Purchase and Sale Agreement is entered into, and to no more than once per month if the Insured has a life expectancy of one (1) year or less. Unless Insured designates a contact under the Life Insurance Policy Purchase and Sale Agreement, Insured agrees that Purchaser may contact Insured as described in this paragraph. If Insured desires, Insured may designate any individual of legal age, who is in regular contact with Insured as a contact for inquiries about Insured's health or medical status ("Insured's Designee"). Insured shall provide the name, address, telephone number and relationship of Insured's Designee, and may change Insured's Designee by delivering written notice of such change to Purchaser. **Viator and Insured each agree and acknowledge that contacts with the Insured may be made by phone, fax, mail or any other method used by Purchaser.**

11. In addition to the loss of coverage on Insured, Viator and Insured each acknowledge that if the Policy is a joint Policy, or contains riders or other provisions insuring the lives of a spouse, dependents or anyone other than Insured, there will be a loss of coverage on those additional insureds, and **Viator or Insured should contact Insurer or their insurance agent to determine if the coverage may be converted in order to avoid losing coverage.**

12. There is no affiliation between the Purchaser and the Insurer.

13. The Purchaser is Habersham Funding, LLC; a licensed viatical settlement provider located at 3495 Piedmont Road NE, Suite 910, Building 11, Piedmont Center, Atlanta, Georgia, 30305. Tel: 404-233-8275.

14. Viator and Insured acknowledge that they have each received a copy of the NAIC's brochure describing the process of viatical settlements.

15. All medical, financial, or personal information solicited or obtained by a viatical provider or viatical 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.

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DISCLOSURE FORM

continued

16. All medical, financial, and personal information solicited or obtained by a viatical settlement agent, broker, or provider about Viator or Insured, including the identity of Viator and Insured and the identity of their family members or significant other, is confidential. The information shall not be disclosed to any person unless the disclosure is: (a) necessary and Viator and Insured have provided written consent to the disclosure (see read and sign the Viator's and Insured's Release – Disclosure of Information on page 28); (b) provided in response to an investigation or examination by the commissioner or other governmental officer or agency; or (c) in connection with the transfer of the contract or policy to another licensed viatical settlement provider or to an entity that provides financing to effect the contract under a written agreement with a licensed viatical settlement provider.

17. The Purchaser does not set or determine compensation for any viatical or life settlement broker involved in this transaction, and such compensation is determined in the sole discretion of the broker. The broker is not affiliated with or an agent of the Purchaser in this transaction. Under the law of certain states, the broker has statutorily defined duties to the seller 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 or life settlement broker in this transaction, you should contact your agent or the broker.**

18. I understand that any person who knowingly presents false information in an application for insurance or a viatical settlement contract, or life settlement contract, is guilty of a crime and may be subject to fines and confinement in prison.

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

____
Signature of **insured**

____
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

____
Signature of policy **owner, if other than insured**

____
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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____

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 _____________________

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AUTHORIZATION TO RELEASE MEDICAL AND PERSONAL INFORMATION

I, the undersigned, hereby authorize any physician, medical practitioner, hospital or medical related facility, insurance company, the Medical Information Bureau, life expectancy estimating 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, their authorized representatives and/or their successors, assignees and designees; and, if the Policy has been in effect for less than five years, to the Insurer. I hereby consent and agree to the release of any and all medical records, which may be requested by HABERSHAM FUNDING, LLC, 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 # ___________, insured by _______________________ ("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. This authorization may be revoked by me at any time except with respect to actions taken in reliance upon it.

____
Signature of **insured**

____
Printed name of insured

____
Address 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

FORM APP-IN MED REL Revised 120105

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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 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 form 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

Initial ________ Date_______

(Continued, please see next page)

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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 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 an application for insurance or a viatical settlement contract, or life settlement contract, 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

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

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LIFE INSURANCE POLICY INFORMATION

I hereby authorize _____________, the issuer of Policy Number and/or Certificate Number _______________insuring the life of _________________________ (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. I respectfully request 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.

I agree that this Release is irrevocable and shall remain valid and in force for a period up to twenty-five (25) years unless a shorter time is required by law. My death or future mental condition shall not terminate this Release. I agree that a photocopy or facsimile of this Release is as valid as an original. I understand 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.

____
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

FORM APP-IN INS REL | Revised 120105

AUTHORIZATION TO RELEASE

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LIFE INSURANCE POLICY INFORMATION

I hereby authorize _____________, the issuer of Policy Number and/or Certificate Number _______________insuring the life of _________________________ (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. I respectfully request 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.

I agree that this Release is irrevocable and shall remain valid and in force for a period up to twenty-five (25) years unless a shorter time is required by law. My death or future mental condition shall not terminate this Release. I agree that a photocopy or facsimile of this Release is as valid as an original. I understand 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.

____
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

FORM APP-IN INS REL Revised 120105

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HABERSHAM
FUNDING LLC

VIATOR'S AND INSURED'S RELEASE – DISCLOSURE OF INFORMATION

I/We authorize Habersham Funding, LLC, to disclose the identity of the Insured and of the Viator, if other than the Insured, to third persons as necessary to effect a viatical settlement of the Policy and as necessary to permit a financing agent to finance the purchase of the policy by Habersham. I/We 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.

_______________________________________ _______________________________
Insured Viator, if other than Insured

State of)
)
County of)

Before me, the above-signed person(s), personally appeared who after being duly sworn acknowledged execution of the preceding instrument.

Sworn to and subscribed before me this ______ day of _____________, 200___.

Notary Public: ___________________________ SEAL

My commission expires: ___________________

FORM APP-IN DISC INFO Revised 120105

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