

  
**HABERSHAM**  
FUNDING LLC  
**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: (MN-APP DISCLOSURE) \_\_\_ **signed by insured** \_\_\_ **signed by owner**  
(if different from insured)
- Medical Release: (MN-APP MED REL) \_\_\_ **signed by insured** \_\_\_ **notarized**
- HIPAA Disclosure: (MN-APP HIPAA) \_\_\_ **signed by insured** \_\_\_ **notarized**
- Life Insurance Policy Information Releases (there are two of these): (MN-APP 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 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 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

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

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

### Please INITIAL all that apply:

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

## APPLICATION QUESTIONNAIRE, Continued

**Information about the Life Insurance Policy OWNER.** Please see page 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 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 the insured or the owner knowingly presents false or fraudulent information in an insurance or viatical 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 or viatical settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding will report all suspected insurance or viatical 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 or viatical settlement fraud and agree to hold Habersham Funding harmless for any such report to law enforcement, regulatory or insurance company officials for suspected insurance or viatical 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) for which I am applying and acknowledge and represent that: (1) I am eighteen years of age or older and am mentally competent; (2) I have a full and complete understanding of the benefits of the policy being sold and of the Life Insurance Policy and Sale Agreement into which I am entering; (3) I am entering into such agreement freely and voluntarily; and (4) **I have\_\_\_\_\_ have not\_\_\_\_\_** been diagnosed with a catastrophic or life-threatening illness and that any such illness was first diagnosed after my life insurance policy was issued.

**[SIGNATURES ON NEXT PAGE]**

## REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

*continued*

\_\_\_\_\_  
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

**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



## DISCLOSURE NOTICE: A NOTICE TO APPLICANTS

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

1. Individuals wishing to sell their policies have alternatives to viatical 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 and legal advisors regarding the options available to you.
2. Some or all of the proceeds from a viatical settlement may be subject to federal income taxation and state franchise and income taxation. You should seek assistance from a personal tax advisor.
3. A viatical settlement may adversely affect an individual's ability to receive supplemental social security income, public assistance and public medical services, including Medicaid and other government benefits and entitlements. You should consult the governmental organization responsible for providing these services.
4. The proceeds of a viatical settlement may be subject to claims of creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.
5. If the policy which is the subject of a viatical settlement is a joint policy, or contains family riders or other provisions insuring the lives of a spouse, dependents, or anyone else other than the viator, there may be a loss of coverage. You should consult your insurance producer or the issuer of the policy for advice.
6. Entering into a viatical 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. You should seek assistance from your financial advisor.
7. All medical, financial, or personal information solicited or obtained by a viatical settlement company or viatical settlement broker about a viator and insured, including the viator's and insured's identity or the identity of family members, a spouse, or a significant other is confidential. Such information may only 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 of this policy including institutional purchasers. You may be asked to renew your permission to share information every two years.
8. You should contact your attorney, accountant, estate planner, financial planning advisor, insurer, insurance agent, tax advisor, or social services agency regarding potential consequences resulting from entering into a viatical settlement before you enter into a viatical settlement contract.
9. The insured may be contacted by the Purchaser or its authorized representative or designees for the purpose of determining the insured's health status. This contact will be undertaken in compliance with state law, if any.
10. You have the unconditional right to rescind a viatical settlement contract within thirty (30) calendar days of the date it is executed by all parties or within fifteen (15) calendar days after you receive the viatical settlement proceeds, whichever is less. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the Purchaser of all amounts paid by Purchaser in connection with the settlement.
11. Funds will be sent to the viator within three (3) business days after the Purchaser has received the insurer's acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated pursuant to the viatical settlement contract.
12. There is no affiliation between the Purchaser and the issuer of the life insurance policy being sold.

MN-APP DISCLOSURE

Revised 012006

**DISCLOSURE NOTICE:  
A NOTICE TO APPLICANTS, continued**

13. The Insured may be contacted by the Purchaser or its authorized representatives or designees for the purpose of determining the insured's health status. This contact will be limited to once every three (3) months following the date the proceeds are released to you, if the insured has a life expectancy of more than one (1) year, and to no more that once per month following such date if the insured has a life expectancy of one (1) year or less. These limitations shall not apply to any contacts with the insured for reasons other than determining the insured's health status.
14. The Purchaser is Habersham Funding, LLC; a licensed viatical settlement provider located at 3495 Piedmont Road NE, Ste 910, Building 11, Piedmont Center, Atlanta, Georgia 30305, Telephone: 404-233-8275.
15. The Purchaser does not set or determine compensation for any viatical settlement broker involved in this transaction, and such compensation is determined in the sole discretion of the viatical settlement broker. The viatical settlement broker is not affiliated with, or an agent of, the Purchaser in this transaction. Under the law of certain states, the viatical settlement broker has statutorily defined duties to the owner of an insurance policy, and both the owner and the insured acknowledge that they have been advised of this fact. **If you have questions about the compensation received by the viatical settlement broker in this transaction, you should contact your agent or the viatical settlement broker.**

**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

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

## 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 the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained.

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 is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.***

\_\_\_\_\_  
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***