


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: (MS-APP DISCLOSURE) ___ **signed by insured** ___ **signed by owner**
(if different from insured)
- Medical Release: (MS-APP MED REL) ___ **signed by insured** ___ **notarized**
- HIPAA Disclosure: (MS-APP HIPAA) ___ **signed by insured** ___ **notarized**
- Life Insurance Policy Information Releases (there are two of these): (MS-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:

2nd Policy:

Insurance Company Name: _____

Policy #: _____ Face Amount: _____ Effective Date: _____

Beneficiary(ies): _____

Premiums: \$ _____ per _____ (month, quarter, year, etc.)

Policy Type (*circle one*): **Group** **Group Conversion** **Individual**

3rd Policy:

Insurance Company Name: _____

Policy #: _____ Face Amount: _____ Effective Date: _____

Beneficiary(ies): _____

Premiums: \$ _____ per _____ (month, quarter, year, etc.)

Policy Type (*circle one*): **Group** **Group Conversion** **Individual**

Has an application for insurance on the insured's life/health ever been declined, rated or modified in any way (including this policy)? Yes ___ No ___ If yes, please describe the circumstances: _____

What is the total face value of life insurance on your life that is NOT being offered for sale here? _____

HEALTH INFORMATION

(please list additional physicians/medical providers on the following pages)

Please provide a brief description of your health condition (*even if you consider yourself well/healthy*):

What is your primary medical condition? _____

When was your primary medical condition first diagnosed? _____

What are your secondary medical conditions or health concerns? _____

When were these diagnosed? _____

Current/Primary Physician: _____

Address & Phone: _____

APPLICATION QUESTIONNAIRE, Continued

Second Physician: _____

Address & Phone: _____

Third Physician: _____

Address & Phone: _____

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco? If so, please describe: _____

Has the insured used (now or ever before) alcoholic beverages? Yes ___ No ___ If yes, please answer:
Frequency: Daily ___ Weekly ___ Monthly ___ Occasionally ___

Average amount consumed each time insured drinks: 1-2 drinks 2-4 drinks 5 or more drinks

Has the insured ever undergone alcohol or other substance abuse treatment? If yes, please describe:

FAMILY HEALTH HISTORY

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

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

Please INITIAL all that apply:

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

APPLICATION QUESTIONNAIRE, Continued

Information about the Life Insurance Policy OWNER. Please see page 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). Any person who knowingly presents false information in an application for insurance or a viatical settlement contract or viatical settlement purchase agreement may be guilty of a crime and prosecuted under state law.**

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; and (3) I am entering into such agreement freely and voluntarily.

[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:

You should carefully read the following points and seek additional advice where appropriate.

1. A Life Insurance Policy Purchase and Sale Agreement enables you to sell your life insurance policy for cash at a discount from its face value, with the result of the loss of all death benefits and all other benefits payable to the current Viators, beneficiary or beneficiaries, or the Insured.
2. There are alternatives to the process of selling a life insurance policy, which you may prefer. Some alternatives, where applicable, are (a) borrowing against the cash value of the life policy, (b) surrendering 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 the policy.
3. Some or all of the sale proceeds may be taxable. Furthermore, some or all of the proceeds of any settlement may be free from federal income tax and from state franchise and income taxes. **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 may assign or otherwise transfer its interests in the Policy or the Life Insurance Policy Purchase and Sale Agreement to a third party after purchase from you.
8. You have the right to rescind the Life Insurance Policy Purchase and Sale Agreement on or before 15 calendar days after you receive the Net Purchase Price (the "Rescission Period"). In order to rescind, you must give Purchaser notice of your decision to rescind and pay 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 Viator immediately upon receipt of full reimbursement of the Purchase Price.
9. Pursuant to the terms of the Escrow Agreement, funds will be disbursed by an Escrow Agent to the Viator within two (2) Business Days after all of the following have occurred: (a) receipt by the Escrow Agent of the originals of fully executed copies of all forms or written authorizations necessary to effect a change in both the beneficiary designation and the ownership of the Policy as contemplated by the Life Insurance Policy Purchase and Sale Agreement; (b) receipt by the Escrow Agent of an assignment by the applicable insurance company which accepts and recognizes Purchaser, its agents, designees or assigns, as the owner, and beneficiary of the Policy; and (c) verification by the Escrow Agent of material information, including (i) the face amount of, and death benefit payable under, the Policy; (ii) all encumbrances on the Policy known to the Insurer, including loans, loan interest, collateral assignments or other liens such as a divorce-related decrees; (iii) verify current owner and beneficiary of record of the Policy; (iv) the next premium due date; (v) the absence of any due but unpaid premiums on the Policy; (vi) that the Policy is in effect and has not lapsed; (vii) the Policy is beyond its contestability and suicide period, and (viii) all closing conditions in the Life Insurance Policy Purchase and Sale Agreement have

MS-APP DISCLOSURE

Revised 010306

been satisfied. Escrow Agent shall provide written confirmation of this information to Purchaser in the form of a

10. certificate signed by a duly authorized representative of Escrow Agent.
11. Purchaser will be the new policyholder or certificate holder pursuant to the Life Insurance Policy Purchase and Sale Agreement.
12. 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 and insured's identity or the identity of family members, a spouse or a significant other, is confidential. This information shall not be disclosed in any form to any person, unless disclosure: (a) is necessary to effect the viatical settlement between the viator and the viatical settlement provider; and (b) the viator and the insured have provided prior written consent to the disclosure; or (c) is provided in response to an investigation by the Commissioner or any other governmental officer or agency.
13. The Viator's and Insured's medical information may be provided to financing entities including individual and institutional purchases.
14. 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.
15. I understand that any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a felony and may be subject to fines and confinement in prison.
16. The Viator and Insured acknowledge that the Purchaser does not set or determine compensation for any viatical settlement broker involved in this transaction, and that such compensation is determined in the sole discretion of the viatical settlement broker. The Viator and Insured understand that the viatical settlement broker is not affiliated with or an agent of the Purchaser in this transaction. Under the law of certain states, the viatical settlement broker has statutorily defined duties to the viator of an insurance policy, and Viator and Insured acknowledge that they have been advised of this fact.
17. There is no affiliation between the Purchaser and the Insurer that issued the Policy.
18. You must also review the disclosures set forth on the attached Appendix A.

I have read and understood the above disclosures.

VIATOR:

(_____)

Date: _____

INSURED:

(_____)

Date: _____

Selling Your Life Insurance Policy

Today it is possible for you to sell your life insurance policy to someone else (a viatical settlement provider) for an immediate cash payment. This financial arrangement, known as a viatical settlement, is best suited for people who are living with an immediate life-threatening illness and facing tough financial choices. A viatical settlement may also be beneficial for individuals who do not have a terminal or chronic illness, but wish to sell the policy for other reasons including, changed needs of dependents, wanting to reduce premiums, and cash for meeting expenses.

It may not always be in your best interest to sell your life insurance policy. Before you take action, you want to be sure you understand:

What future benefits you may lose

What other options may be available

Selling your life insurance policy is a complex financial arrangement. This guide will help you make an informed decision.

We recommend that you:

Evaluate your needs

Check all your options

Understand how the process works

Know your rights

Check with the Mississippi Insurance Department.

Step 1, Evaluate your needs

Before you sell your policy and give up valuable insurance protection, think about whether your need for life insurance has changed since you bought the policy. If it hasn't, selling your policy may not be the right choice. If you sell your policy now, your beneficiaries **will not** be paid a benefit at your death.

If you sell your policy now, remember premiums go up a lot as you grow older. You may not want to pay the higher cost to replace your coverage later.

Step 2, Check all of your options

You may be able to get the cash you need now without selling your policy.

Policy Cash Values

Contact your current life insurance agent or company to see if you have any cash value in your policy. Ask if you can:

borrow from the cash value and still keep the insurance in force,

cancel the policy for its current cash value,

use the cash value as collateral to get a loan from a financial institution.

Your insurance company must tell you about your options if you ask.

Accelerated Death Benefits

Find out if your policy has an "accelerated death benefit." It may be your best option.

Many life insurance policies do have an accelerated death benefit. With that benefit, policyholders who are terminally ill, affected with certain diseases or permanently confined in a nursing home can access 50% or more of a policy's death benefit while still living. An accelerated death benefit could pay you a large part of your policy's death benefit and you could keep your policy.

A very important feature of the accelerated benefit is that when the policyholder dies, the beneficiaries get the remaining death benefit. This means that eventually 100% of the policy benefits will be paid out either to the insured or the beneficiary.

Other considerations

Think about what it will mean if you do sell your policy. Check out the tax implications. Not all proceeds from a viatical settlement are tax-free.

Find out if creditors could claim any of the money you would get from a viatical settlement.

Find out if you will lose any public assistance benefits such as Medicaid or other government benefits if you accept a cash settlement for your life policy.

Comparison Shop

To learn the market value of your policy, it's a good idea to contact three to five viatical settlement providers. Or you could use a viatical settlement broker who would contact several viatical settlement providers for you. Your financial advisor can help you decide whether to work with a viatical settlement provider or through a viatical settlement broker.

Summary

Everyone's financial situation is different. A viatical settlement may or may not be the best approach for you. Check it out for yourself. We recommend that you ask an advisor who is qualified to review your finances to help you review your options.

Step 3, How the process works

If you decide to sell your life insurance policy to a viatical settlement provider, you will enter into a viatical settlement agreement with the provider. You, the seller, agree to accept a cash payment for your policy.

The amount will be less than the face amount the policy would pay upon your death. (For example, you might agree to accept a \$75,000 cash payment for a \$100,000 policy.)

The viatical settlement provider buying your policy:

becomes the new owner of your policy,

names the beneficiary,

collects the full death benefit when you die,

MS-APP DISCLOSURE

Revised 010306

begins paying premiums on the policy, and
may sell your policy again.

There are four basic phases required to complete a viatical transaction.

Phase 1-- Qualifying to sell your policy (underwriting)

The viatical settlement provider will need information about you before making an offer. Usually it will take some preliminary information from you over the phone and send you this paperwork to sign:

a medical release form so the viatical settlement provider can get and review your medical records an authorization form to contact your insurance company to confirm benefit, premium, and ownership of your policy.

To avoid delays, it's important that you give complete and accurate information about your medical history.

If you apply with more than one viatical settlement provider, each will contact your doctor for medical records and your insurance company for policy information.

Phase 2--Calculating the offer

The viatical settlement provider uses the information it gets in the underwriting phase to make an offer. To develop an offer, a viatical settlement provider takes into account various factors including:

Estimated life expectancy and medical condition of the insured. Generally, the shorter the life expectancy of the insured, the more the viatical settlement provider will offer for the policy.

The amount of life insurance coverage.

Loans or advances, if any, previously taken against the policy.

Amount of premiums necessary to keep the life insurance policy in force.

The rating of the issuing insurance company.

Prevailing interest rates.

The minimum payment required by Mississippi Insurance Regulation

Phase 3--Closing the agreement

If you accept an offer, a closing package is forwarded to you, the seller, for approval and signature. Closing documents typically include an offer letter, a viatical settlement contract, and the forms the insurance company needs to transfer ownership of the policy to the viatical settlement provider.

The closing documents are then returned to the viatical settlement provider for its signature.

The viatical settlement provider will put the cash payment owed to you in escrow, if required, and send the signed insurance change forms to the insurance company to record the change.

Phase 4--Receiving the Payment:

Once the insurance company notifies the viatical settlement provider that the changes on the life insurance policy have been recorded, the payment is released to you, the seller, within two business days.

In Mississippi, you may have the right to change your mind about the settlement AFTER you receive the money, provided you return all the money. Miss. Code Ann. § 83-7-217(3) allows 15 days to review your settlement arrangement.

Step 4, Know your rights

State laws

Mississippi provides you with important consumer protections. You'll want to contact the Mississippi Insurance Department if you have any questions about the following consumer protections Mississippi requires:

A viatical settlement broker or viatical settlement provider arranging viatical settlements must be licensed with the Mississippi Insurance Department.

The viatical settlement provider buying your policy must keep your identity and medical history confidential unless you give written consent to tell others.

To protect your proceeds, the viatical settlement provider buying your policy must put your money into an escrow account with an independent party during the transfer process.

You have the right to change your mind about the settlement AFTER you receive the money, provided you return all the money. You have 15 days to review your settlement arrangement.

The new owners of your policy are limited in how often they may contact you about your health status.

Federal tax laws

Two groups of people may receive benefits from a viatical settlement without owing federal income tax:

persons who have been diagnosed with a terminal illness and with a life expectancy of 24 months or less and certain chronically ill individuals.

If you qualify for this federal tax-free treatment, you also must use a viatical settlement provider that is licensed in the state where you live, or, in states where licensing is not required, that complies with the standards of the National Association of Insurance Commissioners' Viatical Settlements Model Act.

Remember that, as when interpreting any tax laws, it's always best to check with your own financial advisor.

Avoiding Consumer Fraud

If you have been contacted by someone who wants you to buy a policy and then sell it immediately, you should contact your the Mississippi Insurance Department. You may be a target for fraud.

If you are asked to buy a life insurance policy for the sole purpose of selling it, you may be participating in fraud.

If you are asked to invest in a viatical settlement, we recommend you contact the Mississippi Secretary of State's Office to learn more about the issues and risks that might be involved in such an investment.

Step 5, Check with your state insurance regulator

State licensing

For a complete list of authorized viatical settlement providers, brokers, and their representatives, call the Mississippi Department of Insurance.

Seller Checklist

Before you sell your policy be sure you know the answers to these questions.

Evaluating your needs

Do you still need life insurance?

Do you have dependents who might rely on your life insurance benefits should anything happen to you?

If you don't need life insurance protection now, what are the chances you'll need it in the future?

Current policy benefits

Can you borrow from the cash value?

Can you cancel the policy for its current cash value?

Can you use the cash value as collateral to get a loan from a financial institution?

Do you have an accelerated death benefit feature?

Taxes and other financial considerations

Is the money you get from selling the policy taxable?

Will the money you get from selling the policy affect your eligibility for government benefits?

Do you need the advice of a tax or estate planning specialist before you decide to sell your policy?

If you sell your policy, can any of your creditors claim the money?

Understanding the process

If you sell your policy, who will be the legal owner?

Is the viatical settlement provider buying your policy licensed?

If you sell your policy, how will the value you get be calculated? What interest rate will be used?

If you sell your policy but then change your mind, can you get your money back?

Will investors have specific information about you, your family or your health status?

How are fees or commissions paid to the viatical settlement broker or provider?

Protections in your state

Contact the Mississippi Insurance Department to find out more about the laws governing viatical settlements in Mississippi.

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 or viatical settlement purchase agreement may be guilty of a crime and prosecuted under state law.

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