



# APPLICATION PACKAGE

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

*A few simple forms help us gather the information  
we need to assist you*

- **Document Checklist** – this helps ensure we have all the information we need to serve you to the best of our abilities. We will not be able to proceed with your file until we have all of the listed items in hand and thoroughly completed.
- **Application** –if you have more than one life insurance policy, please complete the areas on the application for additional policies, or if you have more than one medical provider from whom we’ll need to collect information, please provide complete information for each physician or other information source. *Please note that both the insured and the owner of the policy must complete separate sections of the application (unless the insured and the owner of the policy are the same person).*
- **Representations, acknowledgements and warranties** –be sure to read thoroughly and sign the application, including this section.
- **Disclosure Notice** – information that is important to know if you are considering a viatical or life settlement.
- **Authorization to Release Medical Information** – we need your “okay” to access your medical records and other pertinent information about your current and ongoing health status.
- **Authorization for Disclosure of Protected Health Information** – In keeping with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA Privacy Regulations”), we need your HIPAA-compliant approval on this additional form (also used to access your medical records and other pertinent information).
- **Authorization to Release Life Insurance Policy Information** – again, your permission is required to gather information about your life insurance policy(ies).

## DOCUMENT CHECKLIST

**To ensure that we can process your case quickly and provide you with the most complete feedback possible**, please include all of the requested information and materials. Please check off the documents requested as you gather them and sign below when you have assembled a complete package. Call us toll-free at 1-888-874-2402 if you have any questions.

- Application Questionnaire (Pages 5-12)

(Please note that there are two questionnaires – one for insured and one for owner.)

- Representations, acknowledgements and warranties (Page 13-15)  
\_\_\_\_\_ **signed by insured** \_\_\_\_\_ **signed by owner** (if different from insured)

- Disclosure Notice (Pages 16-17)  
\_\_\_\_\_ **signed by insured** \_\_\_\_\_ **signed by owner** (if different from insured)

- Medical Release (Page 18)  
\_\_\_\_\_ **signed by insured** \_\_\_\_\_ **notarized**

- HIPAA Disclosure (Pages 19-20)  
\_\_\_\_\_ **signed by insured** \_\_\_\_\_ **notarized**

- Life Insurance Policy Information Releases (there are two of these) (Pages 22-23)  
\_\_\_\_\_ **signed by owner** \_\_\_\_\_ **notarized**

- A copy of Owner's and Insured's driver's licenses or government-issued identification cards.

- 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***)

- If on Disability Waiver of Premium, a copy of approval letter from the insurance company \*

### **IF APPLICABLE:**

- 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)

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

*Continued, please see next page.*



DOCUMENT CHECKLIST, Continued

**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.

**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

**The following questions pertain to the INSURED only**

1. Full Legal Name of INSURED: \_\_\_\_\_
2. Please list any aliases or nicknames: \_\_\_\_\_
3. DOB: \_\_\_/\_\_\_/\_\_\_    Male     Female     Height \_\_\_\_\_    Weight \_\_\_\_\_
4. Social Security # \_\_\_\_\_
5. Driver's License # & State: \_\_\_\_\_

Please provide a photocopy of your license.

6. Street Address: \_\_\_\_\_  
     City: \_\_\_\_\_    State: \_\_\_\_\_    Zip: \_\_\_\_\_

**7. Please provide contact telephone numbers for the INSURED and indicate if we may leave a message:**

(Please circle at least one)

Hm: \_\_\_\_\_ (yes/no)

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

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

8. 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 ___

**9. EMPLOYMENT INFORMATION for INSURED**

- a. Are you currently working? Yes \_\_\_ No \_\_\_    Are you retired? Yes \_\_\_ No \_\_\_
- b. What is/was your occupation? \_\_\_\_\_
- c. Are you receiving disability benefits? Yes \_\_\_ No \_\_\_    What kind? \_\_\_\_\_
- d. Are you receiving any of the following public assistance benefits? (*circle which applies*): 1. Supplemental Social Security Income (SSI)    2. Medicaid    3. Food Stamps



APPLICATION QUESTIONNAIRE (INSURED, Continued)

INSURANCE INFORMATION

10. 1st Policy (Policy that you are selling):

- a. Insurance Company Name: \_\_\_\_\_
- b. Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_
- c. Beneficiary(ies): \_\_\_\_\_
- e. Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)
- f. Date last premium payment by you: \_\_\_\_\_ (mo/yr) Amount of last payment: \_\_\_\_\_
- g. Policy Type (circle one): **Individual**            **Group**            **Group Conversion**

11. If the 1st policy is a group policy, please complete the following:

- a. Employer Name: \_\_\_\_\_
- b. Address & Phone: \_\_\_\_\_
- c. Benefits Manager (for your employer): \_\_\_\_\_
- d. May we contact this person in order to gather information about your policy?  
Yes \_\_\_ No \_\_\_

ADDITIONAL POLICIES on the life of the INSURED selling this policy:

12. 2nd Policy:

- a. Insurance Company Name: \_\_\_\_\_
- b. Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_
- c. Beneficiary(ies): \_\_\_\_\_
- e. Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)
- f. Date last premium payment by you: \_\_\_\_\_ (mo/yr) Amount of last payment: \_\_\_\_\_
- g. Policy Type (circle one): **Individual**            **Group**            **Group Conversion**

13. 3rd Policy:

- a. Insurance Company Name: \_\_\_\_\_
- b. Policy #: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Effective Date: \_\_\_\_\_
- c. Beneficiary(ies): \_\_\_\_\_
- e. Premiums: \$ \_\_\_\_\_ per \_\_\_\_\_ (month, quarter, year, etc.)
- f. Date last premium payment by you: \_\_\_\_\_ (mo/yr) Amount of last payment: \_\_\_\_\_
- g. Policy Type (circle one): **Individual**            **Group**            **Group Conversion**

APPLICATION QUESTIONNAIRE (INSURED, Continued)

14. 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: \_\_\_\_\_

15. What is the total face value of life insurance on your life that is NOT being offered for sale here (please remember to include group benefits if any)?  
\_\_\_\_\_

**INSURED'S HEALTH INFORMATION**

16. Please provide a brief description of insured's health condition (*even if considered well/healthy*):  
\_\_\_\_\_  
\_\_\_\_\_

17. What is the primary medical condition? \_\_\_\_\_

18. When was the primary medical condition first diagnosed? \_\_\_\_\_

19. What are the secondary medical conditions or health concerns? \_\_\_\_\_

20. When were these diagnosed? \_\_\_\_\_

21. **Current/Primary Physician:** \_\_\_\_\_

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

22. **Second Physician:** \_\_\_\_\_

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

23. **Third Physician:** \_\_\_\_\_

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

24. Has the insured used any type of tobacco products within the last 24 months (e.g. smoked cigarettes, cigars or pipes, used chewing tobacco)? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_



APPLICATION QUESTIONNAIRE (INSURED, Continued)

25. Has the insured used (now or ever before) alcoholic beverages? Yes \_\_\_ No \_\_\_

a. If yes, please answer: Frequency: Daily \_\_\_ Weekly \_\_\_ Monthly \_\_\_

b. Average amount consumed each time insured drinks:

1-2 drinks [ ] 2-4 drinks [ ] 5 or more drinks [ ]

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

27. FAMILY HEALTH HISTORY for INSURED

Table with 4 columns: Relationship, Age if living?, Deceased?, and If deceased, please list cause and age at time of death. Rows include Father, Mother, Brother, and Sister.

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

28. Please INITIAL all that apply for the INSURED:

- List of statements for initialing: I have never been married, I am married, I am divorced, I am widowed, I have no children, I have minor children, One or more of my minor children are my legal dependents, I have no minor children.



APPLICATION QUESTIONNAIRE, INDIVIDUAL OWNER

**29. This section applies to the Life Insurance Policy OWNER if Owner is a natural person AND the Owner and the Insured are not the same person.**

- ( ) please check this box if the owner is different than the insured.
- ( ) please check this box if the owner and insured are the same person and skip to page 13.
- ( ) please check this box if the owner is not a natural person (ie – a trust, corporation, etc.) and skip this section and go to page 11.

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

31. DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female

32. Social Security #: \_\_\_\_\_

33. Driver's License # & State: \_\_\_\_\_

Please provide a photocopy

34. Street Address: \_\_\_\_\_

35. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**37. Please provide contact telephone numbers for the OWNER and indicate if we may leave a message:**

(Please circle at least one)

Hm: \_\_\_\_\_(yes/no)

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

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

38. 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 ___



APPLICATION QUESTIONNAIRE (INDIVIDUAL OWNER, Continued)

39. EMPLOYMENT INFORMATION for OWNER

- a. Are you currently working? Yes \_\_\_ No \_\_\_ Are you retired? Yes \_\_\_ No \_\_\_
- b. What is/was your occupation? \_\_\_\_\_
- c. Are you receiving disability benefits? Yes \_\_\_ No \_\_\_ What kind? \_\_\_\_\_
- d. Are you receiving any of the following public assistance benefits? (*circle which applies*): 1. Supplemental Social Security Income (SSI) 2. Medicaid 3. Food Stamps

40. Please INITIAL all that apply to the OWNER:

- \_\_\_\_\_ 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. (# under age 18 \_\_\_\_\_ )
- \_\_\_\_\_ 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 (TRUST/CORP OWNER)

**COMPLETE THIS SECTION WHERE OWNER IS A TRUST or CORPORATION**

41. Full Legal Name of Owner (trust name or corporate name) : \_\_\_\_\_

42. TAX ID # for entity: \_\_\_\_\_

43. Has the Entity ever been or are you now a party to a:

Bankruptcy? Yes ___ No ___	Civil suit? Yes ___ No ___	Creditor liens? Yes ___ No ___
Judgments? Yes ___ No ___	Tax lien? Yes ___ No ___	

44. Please check one of the following:

- a. ( ) Owner is a **TRUST**, please provide information for ALL Trustees (if more than two, please attach additional sheet)
- b. ( ) Owner is a **CORPORATION**, please provide information for two Corporate Officers.

45. a. Trustee/Corporate Officer #1 Name: \_\_\_\_\_

b. DOB: \_\_\_/\_\_\_/\_\_\_ Male  Female

c. Driver's License # & State (if individual): \_\_\_\_\_

Please provide a photocopy

d. Street Address: \_\_\_\_\_

e. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

46. **Please provide contact telephone numbers for the TRUSTEE/CORPORATE OFFICER and indicate if we may leave a message:**

(Please circle at least one)

Hm: \_\_\_\_\_(yes/no)

e-mail: \_\_\_\_\_

Wk: \_\_\_\_\_(yes/no)

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

Fax: \_\_\_\_\_(yes/no)



APPLICATION QUESTIONNAIRE (TRUST/CORP OWNER, Continued)

- 47. a. Trustee/Corporate Officer #2 Name: \_\_\_\_\_
- b. DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male  Female
- c. Driver's License # & State (if individual): \_\_\_\_\_  
Please provide a photocopy
- d. Street Address: \_\_\_\_\_
- e. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

48. Please provide contact telephone numbers for the TRUSTEE/CORPORATE OFFICER and indicate if we may leave a message:

(Please circle at least one)

	Hm: _____ (yes/no)
e-mail: _____	Wk: _____ (yes/no)
Other #/cell: _____ (yes/no)	Fax: _____ (yes/no)

## REPRESENTATIONS, ACKNOWLEDGEMENTS, WARRANTIES and CONSENT

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 facilitate a settlement transaction and/or find a purchaser for such policy(ies); Habersham Funding purchases policies for its own account and for the accounts of other parties. Habersham Funding disclaims any duties, fiduciary or otherwise, to Applicant; no principal/agent relationship is created hereby.

Further, insured and owner hereby represent, warrant, acknowledge and agree that: the subject life insurance policy(ies) was legally obtained, and to the best of insured's and owner's knowledge, all of the information contained in the insurance application(s) for the subject life insurance policy(ies) is true, correct, complete and not misleading. **If insured or owner knowingly present false or fraudulent information in an insurance, viatical or life settlement application, then the insured and/or owner are guilty of a crime and may be subject to fines and confinement in prison; insured and owner understand that in some states, Habersham Funding is required by law to report suspected insurance, viatical or life settlement fraud; insured and owner understand, acknowledge and agree that, Habersham Funding will report all suspected insurance, viatical or life settlement fraud it discovers related to the subject life insurance policy(ies).**

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

As insured and owner, I have signed the accompanying medical and policy information releases, and I will authorize any person or entity to release any information or documents required to verify my submissions or otherwise to complete any settlement transaction. Further, I am age eighteen or above and am mentally competent.

[SIGNATURES CONTINUED NEXT PAGE]

REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

*Continued*

**I acknowledge that I have read and understand the contents of the Representations, Acknowledgements and Warranties.**

\_\_\_\_\_  
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

[SIGNATURES CONTINUED NEXT PAGE]



REPRESENTATIONS, ACKNOWLEDGEMENTS AND WARRANTIES

*continued*

**I acknowledge that I have read and understand the contents of the Representations, Acknowledgements and Warranties.**

\_\_\_\_\_  
Signature of **spouse of owner**, *if the owner or spouse resides in a community property state (AZ, CA, ID, LA, NM, NV, PR, TX, WA and WI)*

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

**Must Be Notarized**

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

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

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

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

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

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

**DISCLOSURE FORM**

**You should carefully consider all of the following points and seek financial, insurance, tax and other advice where appropriate.**

1. 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, 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.
2. 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.
3. 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.
4. 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 government agencies and from your legal and financial advisors.
5. 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.
6. In addition to the loss of coverage on Insured, if the Policy is a joint Policy, or contains family 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. You should consult with your Insurer or insurance producer for advice on these matters.
7. The Purchaser may assign or otherwise transfer its interests in the Policy or the Life Settlement Contract to a third party after purchase from you.
8. 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. A change of ownership could in the future limit the Insured's ability to purchase future insurance on the Insured's life because there is a limit to how much coverage insurers will issue on one life. Other financial options may be available to you. Consult your financial advisor or insurance company for more information.

If you have any questions, you may call the Idaho Department of Insurance at 800-721-3272 or 208-334-4250.

**[SIGNATURES ON NEXT PAGE]**

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

<p><b><u>NOTARY</u></b></p> <p>State of _____ County of _____</p> <p>Subscribed and affirmed to before me this _____ day of _____, 20__.</p> <p>Notary Public My commission expires: _____</p> <p>(NOTARIAL SEAL)</p>	<p><b><u>INSURED</u></b></p> <p>By: _____</p> <p>Date: _____</p>
<p><b><u>NOTARY</u></b></p> <p>State of _____ County of _____</p> <p>Subscribed and affirmed to before me this _____ day of _____, 20__.</p> <p>Notary Public My commission expires: _____</p> <p>(NOTARIAL SEAL)</p>	<p><b><u>OWNER</u></b></p> <p>By: _____</p> <p>Date: _____</p>
<p><b><u>NOTARY</u></b></p> <p>State of _____ County of _____</p> <p>Subscribed and affirmed to before me this _____ day of _____, 20__.</p> <p>Notary Public My commission expires: _____</p> <p>(NOTARIAL SEAL)</p>	<p><b><u>HABERSHAM FUNDING, LLC</u></b></p> <p>By: _____ M. Bryan Freeman, President</p> <p>Date: _____</p>

## 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.

**Insured’s Initials \_\_\_\_\_ Date \_\_\_\_\_**

*Continued, please see next page.*



AUTHORIZATION OF RELEASE OF PHI
continued

- 5. Right to revoke authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that any revocation of this authorization shall not apply to the extent that (a) the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained or (b), if this authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and my PHI that is disclosed to the Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowingly presents false information in a life settlement application, contract or agreement 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

## A NOTE ABOUT YOUR AUTHORIZATION(S) TO RELEASE LIFE INSURANCE POLICY INFORMATION

- Policy OWNER must **sign and have notarized** both attached copies of the Authorization to Release Life Insurance Policy Information.



## 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.



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

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

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

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

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Signature of Notary Public

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\_\_\_\_\_  
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