Asset Life Settlements, LLC

1507 Park Center Drive, Unit 1B
Orlando, FL 32835
888-335-4769 ♦ Fax: 321-400-1084
www.assetlifesettlements.com

Policy Evaluation and Application Form

Personal Data

First Insured Name: _____SS #: _____

Current Address: _____

City: _____State: _____ Zip: _____Date of Birth: _____

Second Insured Name: _____SS #: _____

Current Address: _____

City: _____State: _____ Zip: _____Date of Birth: _____

Telephone Numbers: Day: _____ Evening: _____

Marital Status: _____ Male: _____Female: _____ Dependent Children: Yes_____ No _____

Have you been or are you now a party to bankruptcy? Yes_____ No_____
If yes, please attach all discharge papers.

Medical History

Please give a brief description of your medical condition:

_____

_____

Name of Personal Physician: _____

Address: _____

City/State/Zip: _____

Telephone: _____Fax: _____Email: _____

Has the Insured used any tobacco or nicotine products within the last 5 years? Yes_____ No_____

If yes, please explain: _____

_____

Please list the names and phone numbers of any additional Physicians and/or Specialist

Name Phone

_____ _____

_____ _____

_____ _____

Policy Owner Information

Policy Owner(s): _____

Name(s) of Trustee(s): _____SS or Tax ID#: _____

Current Address: _____

City: _____State: _____Zip: _____

Telephone Numbers: Day: _____Evening: _____

Marital Status: _____ Male: _____Female: _____ Dependent Children: Yes_____ No _____

Have you been or are you now a party to bankruptcy? Yes_____ No_____
If yes, please attach all discharge papers.

*****Please list any additional owners or Trustees on a separate sheet.**

Beneficiary Information

Name(s) of Beneficiary(ies): _____

Life Insurance Policy Information

Name of Insurance Company: _____

Policy Number: _____Date of Issue: _____

Coverage/Face Amount: $_____Amount of Premium: _____

Date the Last Premium was Paid: _____Date Next Premium is Due: _____

Policy Owner Type: **Circle one**: A. Individual B. Trust C. Corporation

Policy Type: **Circle one**: A. Term B. Whole Life C. Universal Life D. Survivorship E. VUL F .Other

Loans: $_____Current Surrender Value: $_____

Has this Policy ever lapsed? Yes_____ No _____

What is the Reason for the Sale of this Policy? _____

Fraud Notice

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

Disclosure Notice and Advice to Policy Owner and Insured

1. Some or all of the proceeds of your viatical/life settlement may be taxable under federal income tax and/or state franchise and income tax laws. You should consult a professional tax advisor.

2. The sale of your insurance policy may affect your right to receive Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.

3. Asset Life Settlements, LLC will only process your life insurance policy through licensed Providers/Purchasing Companies to the extent required by applicable law.

4. Asset Life Settlements, Inc. will be compensated. The viatical settlement provider company, not the viator, will compensate Asset Life Settlements, LLC based on a formula that is a percentage of the face value of the life insurance policy. For example: compensation for a $100,000 policy could be: 8% x $100,000 (face value) = $8,000.00. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.

5. There may be a possible alternative to selling your life insurance. This may include the option of an accelerated death benefit or policy loans offered by your life insurance company. You are advised to consult a financial advisor, certified public accountant or an attorney regarding these potential alternatives.

6. The name, business address, and phone number of the entity that serves as independent third-party escrow agent that disburses your settlement proceeds is: [Furnished at your request]. You may, if you wish, inspect or receive a copy of the escrow agreement or documents for your settlement from the escrow agent.

7. Once you have received your proceeds from the sale of your life insurance policy, you will have fifteen (15) days from receipt of the viatical settlement proceeds in which to rescind the transaction. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds. Funds will be sent to you within (3) business days after the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

8. Your entering into a contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator. Assistance should be sought from a financial advisor.

9. Viatical settlement proceeds could be subject to the claims of creditors.

10. The insured may be contacted by Asset Life Settlements, LLC or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

11. All medical, financial, or personal information solicited or obtained by Asset Life Settlements, LLC about the insured/policy owner, including the insured/policy owner's identity or the identity of family members, a spouse, or significant other may be disclosed as necessary to effect the life/viatical settlement between you and the Provider. If the insured/policy owner is asked to provide this information, the insured/policy owner will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. The insured/policy owner may be asked to renew his or her permission to share information every two years.

12. All information provided by a viator or insured to a viatical settlement provider or viatical settlement broker will be shared with the insurer that issued the life insurance policy that is the subject of the viatical transaction.

Applicant's Acknowledgement of Receipt of a Brochure on Viatical/Life Settlements

By my signature hereinafter affixed, I/we confirm and acknowledge that I/we acknowledge receipt of a brochure describing the process of viatical/life settlements.

Signatures

I/We understand that Asset Life Settlements, LLC, has a duty to find the most competitive offer available for my/our life insurance policy (ies). Therefore, I/we hereby grant to Asset Life Settlements, LLC, the exclusive right to broker my/our life insurance policy(ies) which may only be terminated upon thirty (30) days prior written notice.

I/We agree that all of the information provided in this application is material and represent and warrant that all of the information is true and correct to the best of my/our knowledge. I/We acknowledge that I/We have read and understand the contents of the DISCLOSURE NOTICE.

Signature of Insured 1	Printed Name of Insured 1	Date
Signature of Insured 2	Printed Name of Insured 2	Date
Signature Policy Owner–(*if other than insured)*	Printed Name of Policy Owner	Date
Signature Policy Owner 2–(*if applicable)*	Printed Name of Policy Owner 2	Date
Signature of Witness	Printed Name of Witness	Date
Signature of Broker	Printed Name of Broker	Date

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Authorization for Disclosure of Protected Health Information
(HIPAA Compliant)

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of persons authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to (a) Asset Life Settlements, LLC, (b) any viatical settlement provider, (c) any person who may seek to purchase any life insurance policy insuring my life or other insurance product I own, (d) any financing entity of a viatical settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (e) any life expectancy provider, (f) any life insurance company that has issued a life insurance policy insuring my life, and (g) any of the respective affiliates, agents, employees, representatives, advisors, successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (a) through (f), inclusive (each, an "Authorized Recipient").

3. Description of Protected Health Information and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including information relating to psychiatric or neuropsychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment. The purpose of this authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (a) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to any Authorized Recipient and (b) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, that any Authorized Recipient purchases.

4. Expiration of Authorization: This authorization shall remain valid until, and shall expire, two (2) years from the date hereof.

5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: I understand that no authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

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, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such 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 and that all information contained in this authorization is true and correct. 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.

_____

Authorized Disclosures

INDIVIDUAL:

Signature of Insured	Printed Name of Insured	Date
Signature Policy Viator–(*if other than insured)*	Printed Name of Policy Viator	Date
Signature Policy Viator 2–(*if applicable)*	Printed Name of Policy Viator 2	Date
Signature of Witness	Printed Name of Witness	Date

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Authorization for Release of Policy Information

I hereby request and authorize _____(Insert Name of Insurance Company), the issuer of life insurance policy number _____, owned by _____(Insert Name of Policy Owner), and insuring the life of _____ (Insert Name of Insured), to release to Asset Life Settlements, LLC, and/or its agents, successors, assignees, and affiliates, and their authorized representatives, any and all information concerning the above policy (including any conversions thereof or replacements therefore). This includes, but is not limited to, a complete copy of all policies and policy forms, master policies and certificates for any group policies, all applications, policy illustrations, verification of coverage forms, annual or periodic statements, premium information, change of ownership forms, change of beneficiary forms, and collateral and/or absolute assignment forms, as well as all other information reflecting ownership and benefits payable under the policy, liens and assignments, premium waivers, and all provisions of the policy related to the foregoing.

This Authorization shall be effective and remain valid for twenty-four (24) months from the date of signature entered below. However, if any governing law or regulation limits this authorization to a shorter period of time, then this Release shall remain in force for the maximum period of time allowed by law.

I agree that any copy or facsimile of this Authorization shall be as valid as the original.

This Authorization may be signed in counterparts if required to complete execution. This Authorization is effective as to each Insured and each Policy Owner immediately upon witnessing of such individual's signature, and is not conditioned upon signature by other insureds or Policy Owners. It shall be sufficient that the signature on behalf of each party appear on one or more such counterparts. However, witnesses must sign the same sheet at the same time as signature of the person whose signature is being witnessed.

EXECUTED BY THE POLICY OWNER AS FOLLOWS:

Signature Policy Viator	Printed Name of Policy Viator	Date
Signature of Witness	Printed Name of Witness	Date
Signature Policy Viator 2	Printed Name of Policy Viator 2	Date
Signature of Witness	Printed Name of Witness	Date

Consumer Alert

- If you are in good health and someone asks you to sell your life insurance policy, proceed with caution. You may be a target for fraud. Contact the Kansas Insurance Department for more information.
- If you have been contacted by someone who wants you to buy a policy and then sell it immediately, you should contact the Kansas Insurance Department. You may be a target for fraud.
- If you are asked to invest in a viatical settlement, we recommend you contact either the Kansas Insurance Department or the Kansas Securities Commission (785-296-3307) to learn more about the issues and risks that might be involved in such an investment.

Consumer Assistance
1-800-432-2484

This publication was issued as a public service by the
Kansas Insurance Department
Sandy Praeger, Commissioner

420 S.W. 9th St.
Topeka, KS 66612-1678

785-296-3071

E-mail: commissioner@ksinsurance.org
Homepage: www.ksinsurance.org

Selling Your Life Policy

What to Know About Viatical Settlements Before you sell Your Policy

Kansas insurance Department
Sandy Praeger, Commissioner

1-800-432-2484

Selling Your Life Insurance

Today it is possible for you to sell your life insurance policy to someone else and receive an immediate cash benefit to use for whatever reason you choose. This financial arrangement, known as a viatical settlement, is best suited for people who are living with immediate life-threatening illness and facing difficult financial choices.

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

- *What future benefits you may lose*
- *What other options may be available*

This brochure is designed to provide some of that information. However, it only provides a starting point. If you have additional questions, please call us.

The Kansas Insurance Department
Consumer Assistance Division
1-800-432-2484

Make an informed decision

Have your needs changed?

- Before you sell your policy for cash you should carefully consider the loss of valuable insurance protection which you may not be able to get again. Remember that the costs for coverage increase significantly as you age and that you also must be in good health to qualify for coverage.

Check all of your options

- Find out if you have any cash value in your policy. You may be able to (1) borrow from the cash value, (2) cancel the policy for its current cash value, (3) use the cash value as collateral to secure a loan from a financial institution.
- Find out if you have an "accelerated benefit" rider on your policy. If available, it could pay you a substantial portion of your policy's death benefit without requiring you to sell your policy. It may be your best option.

Other considerations

- Check out the tax implications. Not all proceeds from a viatical settlement are tax free.
- Find out if the proceeds would be subject to the claims of any creditors.
- Find out if you will lose any public assistance benefits such as food stamps, unemployement, or Medicaid if you accept a cash settlement for your life policy.

Consumer protections in Kansas

- Any agent or company arranging viatical settlements must be licensed with the Kansas Insurance Department.
- The company buying your policy must keep your identity and medical history confidential unless you give them written consent.
- To protect your proceeds, the company 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 owner of your policy is limited to the number of times they may contact you about your current health status.
- This is a summary of Kansas law. For more detailed information refer to Kansas Statute 1999 Supp.40-2, 140 eta.seq. or consult with your personal advisor.

A viatical settlement is a complex financial arrangement which may require professional guidance. We suggest you find your own personal advisor such as an accountant or tax attorney who will represent your interests.