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? _____

Supplemental Life Insurance Policy Information:

1. Has this Policy or any of its proceeds ever been used as security for a loan made to the original policy owner (or any affiliate of the original policy owner) for the purpose of paying all or part of the ongoing policy premium payments? Yes_____ No _____

2. If Owner purchased this Policy with financial assistance from a lender or investor ("Financier"), do any of the following apply to the financing?

(a) the original policy owner or the Insured received a financial inducement to finance the premiums: Yes_____ No _____

(b) the Financier has a potential interest in the death benefit or possible proceeds from the sale of this Policy: Yes_____ No _____

(c) the financing arrangement included a pre-arrangement to sell this Policy: Yes_____ No _____

If the answer to question 1 or any of the questions in 2 above is Yes, please provide details: _____
_____

3. Has there ever been an option or other arrangement of any kind to purchase, sell or transfer any of the following?

(a) the Policy: Yes_____ No _____

(b) the beneficial interest in the Policy: Yes_____ No _____

(c) the entity owning the Policy: Yes_____ No _____

4. Please state the basis for the original policy owner's (if not the Owner) insurable interest in the life of the Insured(s): _____
_____

5. Does the Insured require substantial supervision due to concerns about his/her health and safety because of severe cognitive impairment or has the Insured been diagnosed or treated by a licensed member of the medical profession consulted by the applicant for any catastrophic, terminal, life-threatening or chronic illness, disease, or medical condition that will reasonably be expected to result in a life expectancy of twenty-four (24) months or less? Yes_____ No _____ If yes, please describe: _____
_____

6. Of the following daily living activities, **(Circle)** any activity listed below which the Insured can perform only with assistance from another person.

Eating	Toileting	Dressing
Mobility	Bathing	Continence

Fraud Notice

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

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. Prior to making the decision to sell the Policy, I/We have had the opportunity to discuss any questions about the transaction with other appropriate professionals such as my/our lawyer, accountant and tax advisor or have freely chosen not to do so.

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.

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

Asset Life Settlements, LLC

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

Disclosures to Owners

(To be signed no later than at time of application for any life settlement contract)

Important-Read This Disclosure Document Before Signing A Life Settlement Contract.

You should carefully read all of the following information and seek financial, insurance, tax and other advice where appropriate.

1. Possible alternatives to life settlement contracts exist, including accelerated death benefits offered by the issuer of the life insurance policy.

2. Some or all of the proceeds of a life settlement contract may be taxable under law. You should seek assistance from a professional tax advisor.

3. Proceeds from a life settlement could be subject to the claims of creditors.

4. Receipt of the proceeds from a life settlement contract may adversely affect the owner's eligibility for Medicaid or other or other government benefits or entitlements and advice should be obtained from the appropriate agencies.

5. The owner has a right to terminate a life settlement contract within 15 calendar days after the receipt of the life settlement proceeds by the owner as provided by Subsection 31A-36-109 (7). If the insured dies during the rescission period, the settlement is deemed to have been rescinded. Rescission is subject to repayment of all life settlement proceeds and any premiums, loans, and loan interest to the provider.

6. Funds will be sent to the owner within (3) three business days after the life settlement provider has received 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.

7. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the owner. Assistance should be sought from a professional financial advisor.

8. Disclosure to an owner shall include distribution of a copy of the National Association of Insurance Commissioners (NAIC) Life Settlement Brochure, dated 2004 or later, that describes the process of life settlements.

Owner's Initials: _____

9. The following language: "All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members or a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years".

10. Following execution of a life settlement, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a life settlement provider licensed in the state in which the owner resided at the time of the life settlement, or by the authorized representative of a duly licensed life settlement provider.

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and received a copy of the disclosure form entitled "Disclosures to Owners", to which this acknowledgement is attached. Further, I/we have received the consumer information booklet entitled "Life Settlements – What You Should Know Before Selling Your Life Insurance Policy" or a similar booklet to keep for my/our records.

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

Owner's Initials: _____

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

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 life 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 life 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.

INDIVIDUAL:

Signature of Insured	Printed Name of Insured	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

Asset Life Settlements, LLC

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

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

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of life settlement providers and producers that are licensed to do business in the state. Contact them to make sure yours are on the list.

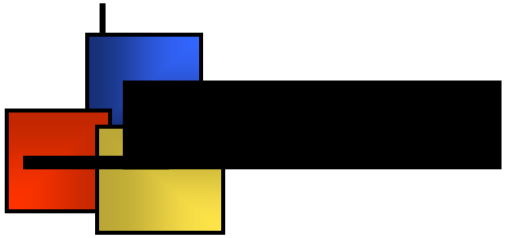
Always Check with Your State

Contact your state insurance or securities departments to learn about the issues and risks of life settlements *if*:

- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy *and* your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy *and* immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state securities department *before* you make a decision.



Selling Your Life Insurance Policy

Understanding Life Settlements

What is a Life Settlement?

A life settlement is the sale of a life insurance policy to a third party. The owner of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the life settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most life settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.

2. Find out if your life insurance policy has an *accelerated death benefit.* An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the life settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.
- Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?