



1507 Park Center Drive, Unit 1B
Orlando, FL 32835
888-335-4769 ♦ Fax: 321-400-1084
www.assetlifeselements.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 or confinement in prison, or both."

Disclosure Notice to Viator and Broker Description Services

1. Some or all of the proceeds of your viatical settlement contract may be taxable under federal income tax and 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 to the extent required by applicable law.
4. Description of Services: Asset Life Settlements, LLC, a licensed viatical settlement broker, will be compensated for its services for negotiating a viatical settlement contract between the viator and a licensed provider having an offer acceptable to the viator. 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. Asset Life Settlements, LLC shall submit to the viator all offers, counter-offers, acceptance, and rejections relating to the placement of the viator's policy within 72 hours after receipt by Asset Life Settlements, LLC.
6. There may be possible alternatives 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.
7. 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.

8. Once you have received your proceeds from the sale of your life insurance policy, you will have thirty (30) days from the date of the contract or fifteen (15) days from receipt of the viatical settlement proceeds, whichever is less, 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 three (3) business days after the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

9. 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.

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

11. The insured may be contacted by the provider or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently once every three (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.

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

13. 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 Settlements

By my signature hereinafter affixed, I/we confirm and acknowledge that I/we acknowledge receipt of a brochure describing the process of viatical 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. 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. 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
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Signature of Insured 2	Printed Name of Insured 2	Date
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Signature Policy Owner—(if other than insured)	Printed Name of Policy Owner	Date
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Signature Policy Owner 2—(if applicable)	Printed Name of Policy Owner 2	Date
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Signature of Witness	Printed Name of Witness	Date
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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.

INDIVIDUAL:

Signature of Insured	Printed Name of Insured	Date
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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 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

Selling Your Policy

If you decide to sell your life insurance policy, you should be aware that Maryland law requires your viatical settlement broker to take certain steps in every transaction. The broker should:

1. Give you a written description of the services that are required on your behalf by state law
2. Disclose all offers, counter-offers, acceptances and rejections relating to the sale of your policy within 72 hours of their receipt
3. Explain in writing within 72 hours before a viatical settlement contract is signed by all parties, the amount of the broker's compensation and how it is calculated; and
4. Make other disclosures regarding your legal rights in a viatical settlement.

If you believe your viatical settlement broker did not make a required disclosure or did not perform a legally required service, you may file a complaint with the Maryland Insurance Administration against the broker. For information on filing a complaint, you may call or write the Insurance Administration or visit our website: www.insurance.maryland.gov

Buying a Life Insurance Policy?

If you are considering buying a life insurance policy as an investment, contact the Securities Division of the Maryland Office of the Attorney General (888-743-0023), for more information.

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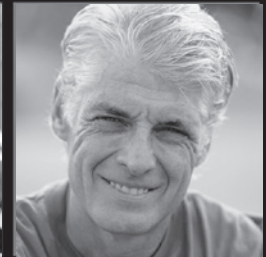
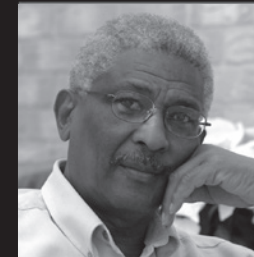
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Governor

Boyd K. Rutherford
Lt. Governor

VIATICAL SETTLEMENTS

A GUIDE TO SELLING YOUR LIFE INSURANCE POLICY



Understanding Viatical Settlements

The Maryland Insurance Administration 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 understand your rights in the transaction, possible consequences and alternative solutions that may better serve your personal situation.

What is a Viatical Settlement?

A viatical settlement is a written agreement for the sale of a life insurance policy to a third party. The owner or certificate holder of the life insurance policy (the *viator*) sells the policy for an immediate cash benefit.

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

A *viatical settlement broker* is the person or company that, for a fee, commission or other consideration, arranges the sale of your life insurance policy.

In Maryland, a viatical settlement broker represents only the viator and has a duty to act in the viator's best interest. Viatical settlement brokers must be both licensed to sell life insurance in Maryland and specifically registered with the Maryland Insurance Commissioner to conduct viatical settlements.

The *viatical settlement provider* is the buyer and becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies. Viatical settlement providers must be registered with the State Insurance Commissioner.

Consider Your Options

If you're selling your policy to obtain cash to pay expenses, check all of your options. You may find a way to receive 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 whether 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 potential buyers to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds from the sale of your life insurance policy are tax-free.
- It's important to know that any of your creditors could make a claim against your cash settlement.
- Find out whether you will lose eligibility for public assistance benefits such as food stamps or Medicaid if you receive a cash settlement.
- The buyer of your policy may 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 viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.
- Remember that, by law, you have the right to change your mind and rescind the transaction within 15 days of receiving the cash payment.

The Maryland Insurance Administration maintains a list of viatical settlement providers and brokers who are registered to do business in the State. The list can be found on the Administration's website: www.insurance.gov.

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, who decides the amount of the settlement offer and how is it calculated?
- 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 private information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?