



APPLICATION FOR LIFE OR VIATICAL SETTLEMENTS

**To obtain the best amount for your life insurance policy, please
read thoroughly and complete these forms and fax to:**

Life Distributors of America - Fax (805) 367-8671

www.lifedistributors.net

t: 877-454-3395 f: 805-367-8671

2801 townsgate road, suite 320, westlake village, ca 91361

APPLICATION FORM & POLICY EVALUATION

Insured Information

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: Married Single Widowed Divorced

Sex: Female Male Dependent Children: Yes No

Have you been or are you now a party to bankruptcy? Yes No

Policy Owner Information

Policy Owner: _____

Name of Trustee: _____ SS # or Tax ID #: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Date of Incorporation/Trust: ____/____/____

Telephone Numbers: Day: (____) _____ Evening: (____) _____

Marital Status: Married Single Widowed Divorced

Sex: Female Male Dependent Children: Yes No

Have you been or are you now a party to bankruptcy? Yes No

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

APPLICATION FORM & POLICY EVALUATION (CONTINUED)

Life Insurance Policy Information

Name of Insurance Company: _____ Policy Number: _____

Policy Beneficiary: _____ Relationship to Insured: _____

Date of Issue: ____/____/____ Face Amount: \$ _____ Premium: \$ _____

Premium Mode: Month Quarterly Semi-Annually Annually

Date Last Premium Paid: ____/____/____ Date Next Premium Due: ____/____/____

Loans: \$ _____ Cash Surrender Value: \$ _____ Illustration Date: ____/____/____

Type of Policy: Term Conversion Whole Life UL VUL SUL SVUL Other

Does this policy have a death benefit extension rider? Yes No

Policy Issue Age: First Insured _____ Second Insured _____

Underwriting Class at Issuance: First Insured _____ Second Insured _____

Policy Issue State: _____ Policy Settlement State: _____

Has this Policy ever lapsed? Yes No

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

Was this policy premium financed? Yes No If yes, what program? _____

Medical History

Please give a brief description of your medical condition: _____

Name of Personal Physician: _____

Address: _____

City/State/Zip: _____

Telephone: (____) _____

Please list the names and phone numbers of any additional Physicians or Specialists:

Name	Phone
_____	(____) _____
_____	(____) _____
_____	(____) _____

APPLICATION FORM & POLICY EVALUATION (CONTINUED)

THE UNDERSIGNED ACKNOWLEDGE(S) THAT ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN THIS LIFE SETTLEMENT APPLICATION IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signature of Policy Owner

Signature of Policy Owner

Print Name of Owner Date

Print Name of Owner Date

Signature of Witness

Signature of Witness

Print Name of Witness Date

Print Name of Witness Date

Signature of Insured

Signature of Insured

Print Name of Insured Date

Print Name of Insured Date

Signature of Witness

Signature of Witness

Print Name of Witness Date

Print Name of Witness Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 Life Distributors of America, LLC, any life expectancy provider, any life settlement provider or their financing entities, any of their respective affiliates, any of their respective agents, employees and representatives, and their respective successors and assigns (each, an “Authorized Recipient”).

3. Description of Protected Health Information Authorized for Disclosure 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 conditions, AIDS/HIV and/or drug or alcohol abuse/treatment. The purposes of this authorization and all disclosures of my PHI made here under are for 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 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.

4. Expiration of Authorization.

This authorization shall remain valid until, and shall expire on, the date that is one (1) year after the date of my death.

5. Right to Revoke Authorization.

I acknowledge and understand that I may revoke this authorization anytime 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.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 healthcare 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 received and retained a copy of this signed authorization for future reference.

INSURED

Insured's Signature

Date

Print Name

Insured's Signature

Date

Print Name

DISCLOSURE TO POLICY OWNERS

READ THIS DISCLOSURE FORM BEFORE ENTERING INTO ANY AGREEMENT TO SELL YOUR LIFE INSURANCE POLICY IN ORDER TO PROTECT YOUR RIGHTS

You should carefully read this entire form and seek professional advice where appropriate before selling your valuable life insurance policy.

1. A life settlement enables you (the "Policy Owner") to sell your life insurance policy for an amount greater than its surrender value but less than its face value.
2. There are alternatives to selling your life insurance policy, which you may prefer. Some alternatives may include (a) borrowing against the cash value of the life insurance policy, (b) surrendering the life insurance policy to the insurer and (c) receiving payment of accelerated death benefits. Not all of these alternatives are available on all policies. You may obtain information on these alternatives from the insurer that issued your life insurance policy.
3. Proceeds of the life settlement could be taxable under federal income tax and state franchise and income taxes. You should obtain advice on these matters from your professional tax advisors.
4. The proceeds you receive from a life settlement may be subject to claims by your creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts. You should obtain advice on these matters from your legal and financial advisors.
5. Receipt of the proceeds from the sale of your life insurance policy may adversely affect your eligibility for Medicaid, Supplemental Social Security Income or other federal and state governmental benefits or entitlements. You should obtain advice on these matters from appropriate agencies and from your legal and financial advisors.
6. Entering into a life settlement agreement may cause you to forfeit certain rights or benefits under your life insurance policy, including conversion rights and waiver of premium benefits that may exist under the policy. In addition, entering into a life settlement agreement for joint policies, policies involving joint riders or any policies covering the life or lives of other persons may result in the loss of these additional coverages. You should obtain advice on these matters from your legal and financial advisors, or from your insurance agent or the company that issued the policy.
7. Life Distributors of America, LLC's compensation shall not exceed a maximum of 8% of the face amount of the life insurance policy sold.
8. The buyer of your life insurance policy may assign or otherwise transfer its interests in your life insurance policy to a third party without your consent.
9. The buyer of your life insurance policy will be the new policyholder or certificate holder pursuant to the life settlement agreement. This will result in all rights related to the policy, including, without limitation, the right to collect benefits under the policy, being transferred to the buyer of your policy. Neither you nor any of the current beneficiaries under the policy will have any further rights to receive any benefits under the policy.
10. All medical, financial or personal information solicited or obtained by Life Distributors of America, LLC or any life settlement provider or life settlement broker about the policy owner or an insured, including the policy owner's or insured's identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement between the policy owner and the life 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 a life settlement purchaser, another life settlement provider or a financing entity that provides funds for the purchase of this policy. You may be asked to renew your permission to share information annually.

DISCLOSURE TO POLICY OWNERS

11. After transfer of the policy under the life settlement agreement, the insured, or his/her personal physician or other personal contacts designated by the insured may be contacted by the buyer of the life insurance policy or its authorized representative on a periodic basis for the purpose of determining the insured's health status.

12. Life Distributors of America, LLC is not in any way affiliated with the insurance company that issued your life insurance policy.

Signature of Policy Owner

Date

Print Name of Owner

Signature of Policy Owner

Date

Print Name of Owner

LIFE DISTRIBUTORS OF AMERICA, LLC

By: _____
Authorized Representative

Date