

OREGON CHECKLIST

Please use this checklist to insure you have enclosed all the documents necessary to process your application efficiently.

- _____ Completed *Personal and Insurance Information Form*
- _____ Completed, signed and witnessed *Authorization to Release Policy Information*
- _____ Signed *Authorization For Disclosure Of Protected Health Information*
- _____ Photocopy of the *Life Insurance Policy*
- _____ Photocopy of the *Insured's Driver's License*
- _____ Read and sign the *Disclosure Statement*
- _____ Photocopy of *Medical Records* for past five years.*
- _____ Photocopy of *Divorce Decree* (if applicable)*
- _____ Photocopy of *Discharge from Bankruptcy* (if applicable).*
- _____ *Statement* from Insurance Company reflecting the policy's cash value, loan value and premium payment structure.*

FAX OR MAIL ALL COPIES AND DOCUMENTS TO:

Stephen M. Watson, President
Viatical Settlement Professionals, Inc.
1910 Byrd Avenue, Suite 203
Richmond, Virginia 23230

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Tel: 804-673-2991
Toll Free: 888-321-9057
Fax: 804-673-1111

*These items are optional at this time, but if included the response time will improve.

"Bringing Benefits to Life..."

CONFIDENTIAL PERSONAL AND INSURANCE INFORMATION

After receiving the following pages of information, we will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign as indicated.

1. Personal Data:

Name of Insured: _____
Social Security #: _____
Current Address: _____
City/State/Zip: _____
County: _____
Telephone Number(s): Daytime () _____ Evening () _____
Date of Birth: _____ Marital Status: _____ Sex: Male () Female ()
Dependent Children: Yes () No ()

If policy owner is different than above:

Name of policy owner: _____
Tax Identification No./Social Security #: _____
Current Address: _____
City/State/Zip: _____
Telephone Number(s): Daytime () _____ Evening () _____

2. Life Insurance Policy Information:

Please enclose a copy of the policy or please complete the following:

Name of Insurance Company: _____
Policy Number: _____
Date Policy was Issued: _____ Coverage/Face Amount: \$ _____
Amount of Premium: \$ _____ How frequently is premium paid? _____
Loans? \$ _____ Current Surrender Value: \$ _____
Type of Policy: Term ___ Whole Life ___ Universal Life ___ Other _____
Is this a group or individual policy? Individual ___ Group ___ Converted Group ___

If group policy, please provide the following information:

Name of Organization Providing Coverage: _____

Name of Benefits Manager or Third Party Administrator: _____

Phone Number: () _____ May we contact the person named above? Yes __ No __

3. Medical History

Please give a brief description of your medical condition: _____

Name of Physician seen for this medical condition:

Name of Physician: _____

Address: _____ Telephone: () _____

City: _____ State: _____ Zip: _____

Who is your primary or family physician? (if different than above)

Name of Physician: _____

Address: _____ Telephone: () _____

City: _____ State: _____ Zip: _____

If there are any other physicians that have treated you in the last three years, you may attach an additional page including their full name, address, and telephone.

AUTHORIZATION TO RELEASE POLICY INFORMATION

I, _____ hereby authorize _____
(Name of Policy Owner) (Name of Insurance Company)

the issuer of insurance policy number _____ insuring the life/lives of:
(Policy Number)

_____ to release any and all
(Name of Insured(s))

information directly to Viatical Settlement Professionals, Inc. (VSPI), and/or its successors, assigns, and authorized representatives. The information may include, but is not limited to, the following information and documents:

- Copy of the policy, including the application therefor.
- Any and all forms promulgated with respect to the Policy and rights of the insured and/or owner, including forms relating to the beneficiary, absolute or collateral assignment, change of ownership, premium payments, loans, withdrawals, payment provisions and/or conversion.
- In-force illustrations of the policy including projections of values into the future.
- All other requested information related to my life insurance Policy.

A photographic copy or facsimile of this Authorization shall be valid as the original. This Authorization shall remain valid for the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

Signature of Policy Owner

Date

Signature of Witness

Date

Printed Name

Printed Name

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my Protected Health Information (“PHI”) as defined under the 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, and any other type of Health Care Provider listed below (each, an “HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. 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 VIATICAL SETTLEMENT PROFESSIONALS, INC. (“VSPI”), its affiliates and any of their directors, officers, employees, agents, independent contractors, service providers or other representatives (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. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) 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 the Authorized Recipient and (2) 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 is purchased.

4. Expiration of Authorization: This authorization shall remain valid until, and shall expire on, the date of my death.

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. No HCP or other covered entity may condition your treatment, payment, enrollment or eligibility for benefits on whether you 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 HIPAA. 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 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.

Signature of Individual

Signature of Personal Representative of Individual
(if necessary)

Print or Type Name of Individual

Description of Personal Representative's Authority
(Power of Attorney, Guardian *ad litem* or similar status)

Date: _____

Date: _____

VIATICAL SETTLEMENT PROFESSIONALS, INC.

DISCLOSURE STATEMENT FOR LIFE SETTLEMENT CONTRACTS

(BROKER)

OREGON

Read this disclosure statement before signing any life settlement contract. Oregon law permits a terminally ill person to sell his or her life insurance policy. This sale is referred to as a “life settlement” or a “viatical settlement.”

This life settlement contract is an arrangement in which you will sell or assign the death benefit or ownership of your life insurance policy to the life settlement provider of your choice. In return, the life settlement provider will pay you a negotiated amount for the sale or assignment. You must be terminally ill at the time the life settlement contract is entered into.

In place of the legal term “life settlement provider,” the term “life settlement company” will be used in this disclosure statement. This statement contains general information that will help you make a decision regarding your life insurance policy.

OTHER OPTIONS

If you are thinking about a life settlement contract, you should consider the possible disadvantages and look at other options. Some options may allow you to meet your needs and also keep part or all of your life insurance policy. These options also may reduce or eliminate tax liability and other possible costs, such as a loss of government benefits that may occur if you receive cash from a life settlement. Some of these disadvantages are described later.

TALK TO YOUR INSURANCE COMPANY OR AGENT

You should first contact your insurance company or the insurance agent who sold you the life insurance policy to discuss the following options:

Many insurance policies offer accelerated benefits and will pay you a percentage of the expected death benefit while you are living. This option may enable you to retain ownership of any policy balance and may pay a higher percentage of the death benefit.

Many insurance policies allow the policyholder to take out a loan on the policy or withdraw cash from the policy, up to the level of its current cash value. Either option also may enable you to retain ownership of your policy. The amount may be as much as you would receive in a life settlement.

CHECK AVAILABLE SERVICES

Ask about existing services and support that may meet your needs. Following are some agencies that will provide information on available services:

Senior and Disabled Service Division (SDSD) of the Oregon Department of Human Resources. Check the “State Government” section of your phone book for the office in your area. The SDSD office will also give you the location and phone number of your local Area Agency on Aging.

Social Security: (800) 772-1213

Oregon Health Plan: (800) 359-9517

Oregon Medical Insurance Pool (for people who have been refused health insurance coverage or can't obtain health insurance at reasonable cost because of preexisting medical conditions): (800) 542-3104

Oregon HIV Advocacy Center (for people with HIV disease). Information on life settlement contracts also available: (800) 777-2437, ext. 151.

Community Health Insurance Program (for people with HIV disease). Information on life settlement contracts also available: (800) 805-2313.

LOANS

You might be eligible for a loan from a lender, using your insurance policy as collateral, or you may be able to obtain a loan from a relative or friend, although such loans are without consumer protection.

BE SURE YOU UNDERSTAND THE FOLLOWING ABOUT LIFE SETTLEMENTS LIFE SETTLEMENTS MAY HAVE THE FOLLOWING DISADVANTAGES:

A life settlement payment may be taxable. You should seek advice from a personal tax advisor.

A life settlement payment may cause you to lose your eligibility for Medicaid or other government benefits or entitlements. You should seek advice from your local Senior and Disabled Services Office, Social Security, and other appropriate agencies.

A life settlement payment may be subject to the claims of creditors.

SHOP AROUND

Different life settlement companies may offer you widely differing amounts to buy your life insurance policy. It's important for you to get quotes from several different life settlement companies before signing a life settlement contract.

State law requires that life settlement companies be licensed by the State and that payment for a life insurance policy meet standards relating to life expectancy estimates. Life settlement companies must estimate life expectancy according to sound actuarial principles, but individual life settlement companies could make different life expectancy estimates.

If you want a list of life settlement companies licensed to do business in Oregon, call the Insurance Division, (503) 947-7980.

IF YOU NEED CASH NOW:

Consider the options offered by your insurance company

Get quotes from as many life settlement companies as possible.

YOU HAVE A RIGHT TO KNOW THE FOLLOWING:

The life expectancy figure the life settlement company is using and the minimum required payment for that life expectancy.

The amount a life settlement company offers you depends on various factors, including average life expectancies for persons with the given condition or illness, and is subject to minimum amounts set by the Oregon Insurance Division.

I HAVE READ THIS DOCUMENT, THE OREGON DISCLOSURE STATEMENT FOR LIFE SETTLEMENT CONTRACTS (BROKER).

Signature of Policyholder/Certificate Holder

FEDERAL TAX LAWS

Two groups of people may receive benefits from a viatical settlement without owing federal income tax:

1. Persons who have been diagnosed with a terminal illness and with a life expectancy of 24 months or less, and
2. Certain chronically ill individuals.

If you qualify for this federal tax-free treatment, you also must use a viatical settlement provider that is licensed in the state where you live, or, in states where licensing is not required, that complies with the standards of the National Association of Insurance Commissioner's Viatical Settlements Model Act.

Viatical Settlement Professionals, Inc. t/a VSP, Inc. is not acting as a tax advisor. When interpreting tax laws it is best to check with your financial advisor. It is recommended that a tax advisor be consulted on such issues. The undersigned understands that the function of the broker is solely to secure a buyer for the life insurance policy and there are no representations or warranties about the financial status of the buyer, the legal status of the buyer or any subsequent purchaser, or of any tax consequences of the transaction. The undersigned releases and holds harmless the broker in this transaction of any claims resulting from this transaction other than intentional fraud.

I have read the above informational and disclosure statement and enter into a viatical settlement knowingly and voluntarily.

Signature

Date

Witness

Date

VSPI
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