

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*
- _____ 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.
2 West Runswick Drive
Richmond, Virginia 23238

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Tel: 804-740-3900
Toll Free: 888-321-9057
Fax: 804-740-8880

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

"Bringing Benefits to Life..."

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

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: _____