



## Peachtree Life Settlement Application

Confidential Personal and Insurance Information

Peachtree will evaluate the information set forth herein. Please complete the following forms and sign where indicated. Please be careful when completing this form. The "Seller" refers to the Owner of the policy the "Insured" is the measuring life under the policy.

### 1. Personal Data

Name of Seller (i.e. the Owner of the policy)

\_\_\_\_\_

Social Security \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number(s): Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female Marital Status: \_\_\_\_\_

Spouses Name \_\_\_\_\_

Social Security #: \_\_\_\_\_

#### If Seller is a Trust:

If Seller is a Trust please provide a list of all Trustees, their addresses and phone numbers:

Trustee #1 \_\_\_\_\_

Trustee #2 \_\_\_\_\_

Trustee #3 \_\_\_\_\_

Seller must attach a copy of the trust agreement and any amendments or addendums thereto.

If Seller is a corporation list the name, title, addresses and phone number of principal officers:  
Seller must attach a copy of the relevant corporate documents evidencing your authority to execute the contract on behalf of the corporation.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Has Seller ever been divorced?     Yes             No             N/A  
 Dependent Children:                 Yes             No             N/A  
 Has Seller ever filed for bankruptcy?  Yes             No            If yes, when? \_\_\_\_\_  
 Is Seller currently employed         Yes             No            If No, date last worked \_\_\_\_\_

**If the Insured is not the Owner:**

Name of Insured: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Current Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone Number(s): Daytime (    ) \_\_\_\_\_ Evening (    ) \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**2. Life Insurance Policy Information**

*(Please enclose a copy of your insurance policy with this application)*

Name of Insurance Company: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Death Benefit/Face Amount: \_\_\_\_\_  
 Date Policy was Issued: \_\_\_\_\_ Cash Surrender Value: \_\_\_\_\_  
 Amount of Premium: \$ \_\_\_\_\_  
 How frequently is premium paid? \_\_\_\_\_

Type of Policy:     Term             Whole Life             Universal Life             Other \_\_\_\_\_  
 Is this a group or individual policy?     Individual             Group             Converted Group  
 Is this a survivorship policy?             Yes                     No

**If group policy, please provide the following information:**

Name of Organization Providing Coverage:  
 \_\_\_\_\_  
 Name of Benefits Manager or Third Party Administrator:  
 \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_



**3. Medical History of Insured**

Please give a brief description of medical condition of the Insured:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of Attending Physician of Insured:**

Name of Insured’s Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_

**Insured’s Primary or family physician? (If different than above)**

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (    ) \_\_\_\_\_ Fax Number: (    ) \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Policy Owner

Printed Name

Date

Please attach a copy of your Insurance Policy.

Please attach a copy of the Seller’s photo ID issued by State or Local Government.



## AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Life Settlement Corporation and/or its authorized representatives or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby expressly authorize such use and disclosure. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that 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 Insured	Date	Signature of Viator	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date
_____	_____	_____	_____
Signature of Witness	Date	Signature of Witness	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date



**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, the undersigned individual, authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) 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 (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 Life Settlement Corporation and of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, credit enhancers, 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 Life Settlement Corporation purchases.
4. Expiration of Authorization: This authorization shall remain valid until, and shall expire, one year after 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 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 received and retained a copy of this signed authorization for future reference.

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Personal Representative of Individual

Description of Personal Representative’s Authority:

\_\_\_\_\_  
Print or Type Name of Individual

\_\_\_\_\_  
(Power of Attorney, Guardian ad Litem or similar status)

Date: \_\_\_\_\_

Date: \_\_\_\_\_



Life Settlement Corporation  
3301 Quantum Boulevard, 2<sup>nd</sup> Floor • Boynton Beach, FL 33426  
Phone: 800.444.9820 • Fax: 800.821.7391

---

Please fax all applications to Peachtree Life Settlements at:

# Fax - (800) 821-7391

<b>To:</b>	Peachtree Life Settlements	<b>From:</b>	_____
<b>Company Name:</b>	_____		
<b>Fax:</b>	_____	<b>Pages:</b>	_____
<b>Phone:</b>	_____	<b>Date:</b>	_____