

Open Life Settlements

Application to Broker Life Insurance Policy

Policyowner Information							
First Name		Initial		Last Name			
SSN		DOB		State of Residence			
Name of Trust (if applicable)							
Street Address				City		St	
Street Address 2				ZIP			
Phone	()	Phone	()	Cell	()		
E-mail				Marital Status			
Have you ever declared bankruptcy? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for each bankruptcy please list the date you filed your bankruptcy petition and the date the discharge was issued. Please attach a copy of the final decree to this application.							
Have you ever been divorced? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for each divorce please list the date you filed your divorce petition and the date the divorce was issued. Please attach a copy of the final divorce decree and any relevant settlement agreements to this application.							
Pending Lawsuits, Dependent Children, Employment, and Other Notes							

Policy Information				
Insurer			Policy Number	
Date of Issue		Type		
Premium			Face Value	
Loans				
Liens			Cash Value	
Notes				

Initial: _____

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Beneficiary Information									
First Name		Initial		Last Name					
SSN (if known)			DOB						
Street Address			City			St			
Street Address 2			ZIP						
Phone	()	Phone	()	Cell	()				
E-mail									
Notes									

Beneficiary Information									
First Name		Initial		Last Name					
SSN (if known)			DOB						
Street Address			City			St			
Street Address 2			ZIP						
Phone	()	Phone	()	Cell	()				
E-mail									
Notes									

Insured Information									
First Name		Initial		Last Name					
SSN			DOB			Sex			
Street Address			City			St			
Street Address 2			ZIP						
Phone	()	Phone	()	Cell	()				
E-mail									
Relationship to Owner and Notes									

Initial: _____

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Insured Medical Care Providers			
Instructions: Please list all medical care providers you have visited <i>in the last five years</i> (e.g., physicians, specialists, etc.) and their location (e.g., name of hospital, clinic, etc.)			
Primary Care Physician			
Name		Phone	()
Location			
Physician or Specialist			
Name		Phone	()
Location			
Physician or Specialist			
Name		Phone	()
Location			
Physician or Specialist			
Name		Phone	()
Location			
Physician or Specialist			
Name		Phone	()
Location			

Hospital Admissions (last five years)			
Name			
Location		Phone	()
Name			
Location		Phone	()
Name			
Location		Phone	()
Name			
Location		Phone	()
Name			
Location		Phone	()

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Insured Medical Information	
Medical History	
Medical Conditions and Prescriptions	
Terminally III? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Representations by Policyowner	
<p>I represent that the information is true, complete, and accurate to the best of my knowledge. I agree to inform Open Life Settlements of any material change in the information contained in this application.</p> <p>I understand that this information above will be used to seek offers for the purchase of a life insurance policy that I own. I represent that I am competent and legally able to enter such a sale. I represent that I seek to enter this transaction of my own accord, and not for the benefit or at the direction of any third party.</p> <p>I understand that Open Life Settlements does not give legal, financial planning, or tax advice, and will consult with appropriate professionals. I understand that the proceeds of a life settlement are income that may result in tax liability and affect my eligibility for public assistance.</p> <p>I understand that there is no guarantee that Open Life Settlements will obtain any offer for my policy.</p>	
<p><i>I, the undersigned, hereby acknowledge that any person who knowingly presents false information in this settlement application is guilty of a crime, and may be subject to fines and/or imprisonment.</i></p>	
Signature	
Signed by	Date

Broker Name: _____

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HIPAA Release

1. I authorize all health care providers, including physicians, nurses, and all other persons (including entities) who may have provided, or be providing, me with any type of health care, to disclose all of my protected health information ("PHI"), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, to Open Life Settlements, LLC and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives ("OLS"). I authorize each health care provider to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing OLS 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 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, including any conversions thereof or replacements therefore, that OLS brokers.
3. Information disclosed by a health care provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR § 164.
4. This authorization may be revoked by a writing signed by me or by my personal representative.
5. This authorization shall expire two years after my death unless validly revoked prior to that date.

I certify that I am executing and delivering this authorization freely and unilaterally 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's Name: _____

Insured's Birth Date: _____

Insured's Social Security Number: _____

Insured's Signature: _____ Date: _____

Note: If a representative is authorizing this HIPAA release, please attach the health care power of attorney and complete the section below in lieu of the insured's signature.

Representative's Name: _____

Representative's Signature: _____ Date: _____

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Life Insurance Information Release Form

Policyowner: _____

Insured: _____

Insurer: _____

Policy Number: _____

I, _____, authorize the release to Open Life Settlements, LLC ("OLS"), its agents, affiliates, and designees, of any and all information concerning the above policy. I understand and authorize OLS to use and share this information with third parties for the purpose of obtaining offers for a life settlement. I direct the insurer listed above and its agents to comply with any requests for information about my policy from OLS. This consent shall be valid for 12 months from the date of signing, and any reproduction of it is as valid as the original copy.

I understand that I may withdraw this consent as required by any applicable law.

Policy Owner Signature

Date

Type or Print Name

Social Security Number

Witness Signature

Date

Type or Print Name

Note: If a representative is authorizing this release, please attach the power of attorney and complete the section below in lieu of the Policy Owner's signature.

Representative's Name: _____

Representative's Signature: _____ Date: _____

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DISCLOSURE TO POLICYOWNER

The owner of the life insurance policy to be viaticated, the viator, should be aware of the following:

1. That there are possible alternatives to a viatical settlement contract including any accelerated death benefits or policy loans offered under the prospective viator's life insurance policy.
2. That some or all of the proceeds of the viatical settlement contract may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax adviser.
3. That proceeds of the viatical settlement contract could be subject to the claims of creditors.
4. That receipt of the proceeds of a viatical settlement contract may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
5. That the viator may have the right to rescind a viatical settlement contract for a short period (typically 10 to 15 days) after the receipt of the viatical settlement proceeds by the viator, as provided by state law or the life settlement contract, and, if the insured dies during the rescission period, the settlement contract may be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans and loan interest to the viatical settlement provider or viatical settlement purchaser.
6. That funds will be sent to viator within three (3) business days after the viatical settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
7. That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator, and assistance should be sought from a financial adviser.
8. That when entering into a viatical settlement contract, having a recent physical exam is in the viator's best interest, since an accurate life expectancy can only be predicted based on current medical records.
9. That all medical, financial, or personal information solicited or obtained by a viatical settlement provider or 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 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.
10. That the insured may be contacted by either the viatical settlement provider or viatical settlement broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once per year if the insured has a life expectancy of more than two years, once every three months if the insured has a life expectancy of more than

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one year but less than two years, and no more than once per month if the insured has a life expectancy of one year or less.

I have received the most current form of brochure describing the process of viatical or life settlements prepared by the National Association of Insurance Commissioners and provided as part of the viatical settlement disclosure.

Signature of Insured Date Signature of Policy Owner (Viator) Date

Printed Name Date Printed Name Date

Signature of Witness Date Signature of Witness Date

Printed Name Date Printed Name Date

OLS Representative Date Printed Name Date

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Broker's Certification of Distribution of NAIC Brochure

I, _____, certify to Open Life Settlements, LLC, that I have given
_____ the most recent copy of the NAIC brochure on the process of viatical and
life settlements.

OLS Representative Date

Printed Name Date

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Broker of Record Letter

Policyowner: _____

Insured: _____

Insurer: _____

Policy Number: _____

I, _____, have agreed to seek offers for the purchase this policy by a life settlement provider. My broker of record for the sale of the above mentioned policy is Open Life Settlements, LLC. No other broker is authorized to solicit or accept offers on my behalf. This authorization shall remain in effect until revoked in writing by me.

Policyowner Signature

Date

Type or Print Name

Social Security Number

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Premium Financing

Has this policy been financed, directly or indirectly, by a third party? **Check one: Yes No** If yes, please explain below.

Other Attempts to Sell Policy

Have you ever sought offers to purchase this policy, whether directly from a life settlement provider or through a life settlement broker? Have you or do you plan to retain the services of any other life settlement broker to seek offers for this policy? **Check one: Yes No** If yes, please indicate below the name of any life settlement broker used and all providers to which the policy was submitted.

I understand that Open Life Settlements does not accept engagements that are not exclusive, and that seeking offers for my policy with another broker may impair the ability of Open Life Settlements to obtain offers from and organize a competitive bidding process between the life settlement providers in my state.

Signature of Policy Owner (Viator) Date

Printed Name

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Checklist

- Trust agreement or business information (if applicable)
- Bankruptcy final decree (if applicable)
- Divorce decree and settlement agreement (if applicable)
- In-force illustration to 100
- Copy of policy and all riders
- Copy of last premium statement
- Copy of policy owner driver's license or other photo ID (front and back)

Mail the completed application to your local representative or the following address:

Open Life Settlements, LLC
228 Park Ave S #90891
New York, New York 10003

Copies of applications may be e-mailed to applications@openlifeselements.com (or faxed to 704.949.2688) to speed initial processing.

Special instructions for policies with multiple insureds: For each insured, please make a copy of pages two through five of the application. Each insured must complete the insured information on page two, the medical information on pages three and four, and both HIPAA releases.

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information (“PHI”) as follows:

- A) **Classes of Persons Authorized to Disclose My Protected Health Information:** I hereby authorize each physician, doctor, physician practice group, nurse, hospital, and any other health care provider (each considered an “Authorized Discloser”) to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this authorization. This authorization terminates any agreement I may have made with my health care provider(s) to restrict my PHI and I instruct my provider(s) to release and disclose my entire medical record without restriction.

- B) **Person Authorized to Receive My Protected Health Information:** I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to AVS Underwriting, LLC and any of its officers, partners, employees, agents, independent contractors or other representatives (collectively known as the “Authorized Recipient”). They may also disclose this information as allowed by law.

- C) **Description of Protected Health Information Authorized for Disclosure and the Purpose for Such Disclosure:** This authorization shall apply to any and all of my PHI, including but not limited to, medical records, charts, laboratory reports, test results, or similar information or knowledge of me or my health condition, including but not limited to, PHI relating to AIDS/ARC/HIV, Alcohol and/or Drug Abuse, Mental Health and Communicable Diseases, whether or not personally identifiable or protected under any federal or state confidentiality or privacy law or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient to: (1) evaluate or cause evaluation to be prepared for a life expectancy based upon my health and medical status and condition in connection with all aspects of a viatical or life settlement transaction, and, (2) to verify or update said PHI on me through a process known as tracking or monitoring of my health, medical status, or life activities should the “Authorized Recipient” be retained to perform such.

- D) **Right To Revoke Authorization:** I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser provided any revocation of this authorization shall not apply to the extent that an Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

I further 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 when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure that may no longer be protected by the same rules that applied in the first instance. A photocopy of this authorization is as valid as an original.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. 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.

(Signature of Individual)

(Print or Type Name of Individual)

(Date)

(Date of Birth)

(Social Security Number)