



4913 Bellview Drive
Bellaire, TX 77401
Phone: 713-557-9443
Fax: 713-662-0353
www.selectlife.net



Key Information to evaluate a potential Life Settlement:

- Completed Prequalification Worksheet
- Completed Life Settlement Questionnaire
 - Medical records (as current as possible) going back for 5 years
 - A list of all physicians consulted during the past five years (name, address and telephone numbers)
- An in-force illustration showing level death benefit to maturity (at minimum premium and zero cash value at maturity)
- A copy of the last annual statement for the policy
- A signed copy of the “Authorization for the Disclosure of Health Information”
- A signed copy of the “Authorization for the Release of Policy Information”

While an indicative quote can often be obtained from incomplete information, a well documented file is the real key to a timely and competitive offer.

Once an offer has been made and accepted all of the information requested above (plus any additional information the Provider requests) must be provided before a closing document can be prepared.



Life Settlement Prequalification Worksheet

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Prospect Name(s) _____

Agent Name _____

Date _____

General Criteria

- | | |
|---|---|
| <input type="checkbox"/> Insured over age 65 (both if survivorship) | <input type="checkbox"/> Policy Face Amount Over \$100,000 |
| <input type="checkbox"/> Insurance Company Rated B+ or Better | <input type="checkbox"/> Policy is Past its Contestability Period |

Total A & B of 10 Points or Higher—Submit for Analysis

| | Point Score | Part A-Insured (if survivorship, use healthier insured) |
|--------|-------------|--|
| 1 Pt. | | Male Age 70 or Younger Female Age 73 or Younger |
| 2 Pts. | | Male Age 71-74 Female Age 74-77 |
| 3 Pts. | | Male Age 75-79 Female Age 78-82 |
| 4 Pts. | | Male Age 80+ Female Age 83+ |
| 1 Pt. | | In Good Health |
| 2 Pts. | | Minor Health Problems |
| 3 Pts. | | Significant Health Change Since Policy Issue |
| 4 Pts. | | Serious Health Problems |
| | | Part B-The Policy |
| 1 Pt. | | Whole Life |
| 2 Pts. | | Survivorship |
| 3 Pts. | | Convertible Term |
| 4 Pts. | | Universal or Joint Survivorship with 1 Deceased |
| 1 Pt. | | Cash/Loan Value Exceeds 30% of Death Benefit |
| 2 Pts. | | Cash/Loan Value=20%-29% of Death Benefit |
| 3 Pts. | | Cash/Loan Value=10%-19% of Death Benefit |
| 4 Pts. | | Cash/Loan Value=Less Than 10% of Death Benefit |
| 1 Pt. | | Premium Exceeds 7% of Death Benefit |
| 2 Pts. | | Premium=5%-7% of Death Benefit |
| 3 Pts. | | Premium=3%-5% of Death Benefit |
| 4 Pts. | | Premium=Less Than 3% of Death Benefit |
| | | Total Score |



Life Settlement Application

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| | | | | |
|------------------------|----------------------|-----|----------------|-------------------|
| Primary Insured's Name | Date of Birth | Sex | Marital Status | Social Security # |
| Second Insured's Name | Date of Birth | Sex | Marital Status | Social Security # |
| Address | City, State | | Zip | |
| Daytime Phone Number | Evening Phone Number | | | |

Life Insurance Policy Information-Policy #1

| | | |
|--------------------------------------|---|------------------------|
| Insurance Company | Policy Number | Date of Issue |
| Face Amount \$ | Existing Policy Loan | Current Annual Premium |
| Current Cash Surrender Value \$ | Policy Type (circle one): Universal Life Whole Life Variable Life Term Survivorship Group Other- | |
| Policyowner (if other than insured)* | Policyowner's Social Security # or Tax ID # | Drivers Lic. # (State) |
| Policyowner's Address | | |
| City, State | Zip | Phone |
| Beneficiary Name | | |

***For additional owners, please attach additional sheet as necessary.
*If policyowner is trust, please list trustee(s), addresses & phone numbers.***

Trustee _____

Address _____

(Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)

Has the policyowner ever declared bankruptcy? Yes or No

Has policyowner been divorced? Yes or No

Is the policyowner currently a defendant in a legal proceeding? Yes or No



Life Insurance Policy Information-Policy #2

| | | |
|--------------------------------------|---|------------------------|
| Insurance Company | Policy Number | Date of Issue |
| Face Amount \$ | Existing Policy Loan | Current Annual Premium |
| Current Cash Surrender Value \$ | Policy Type (circle one): Universal Life Whole Life Variable Life Term Survivorship Group Other- | |
| Policyowner (if other than insured)* | Policyowner's Social Security # or Tax ID # | Drivers Lic. # (State) |
| Policyowner's Address | | |
| City, State | Zip | Phone |
| Beneficiary Name | | |

For additional owners, please attach additional sheet as necessary.
**If policyowner is trust, please list trustee(s), addresses & phone numbers.*

Trustee _____

Address _____

(Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)

Has the policyowner ever declared bankruptcy? Yes or No

Has policyowner been divorced? Yes or No

Is the policyowner currently a defendant in a legal proceeding? Yes or No



Primary Insured Medical Information

| | | |
|--|---------|-------|
| <i>Brief Description of Insured Medical History and Condition(s)</i> | | |
| Primary Physician Name | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |

For additional specialists, please attach additional sheet as necessary.



Second Insured Medical Information

| | | |
|--|---------|-------|
| <i>Brief Description of Insured Medical History and Condition(s)</i> | | |
| Primary Physician Name | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |
| Insured's Specialist and Specialty | Address | |
| City, State | Zip | Phone |
| Date and Reason last seen | | |

For additional specialists, please attach additional sheet as necessary.



Authorization for Disclosure of Protected Health Information (HIPAA Compliant)

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For Life Settlement

The undersigned insured (hereafter referred to as “I”, “me” or “my”), 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. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, (“Authorized Discloser”) to provide Select Life Settlement Corporation and/or any of its officers, employees, agents, or service providers with any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, AIDS/HIV, drug or alcohol abuse, of or related to the insured.
2. 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 treatments 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.
3. I understand that Registered Licensed Providers and their medical underwriters (“Authorized Recipients” named below) will use information released or obtained pursuant to this Authorization for the purpose of tracking my ongoing health status and the pursuing and/or completing the sale of life insurance policy on which I am the insured, and I hereby expressly authorize such use and disclosure.
4. I agree that this authorization shall remain valid for twenty-four (24) months from the date thereof absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under and that a photographic copy or facsimile of this Authorization shall be valid as the original.
5. Right to Revoke Authorization: I understand that I may withdraw the consent of this Authorization under any applicable state statute or regulation. I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser 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 Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser 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: This authorization is voluntary and I am not required to sign. No Authorized Discloser 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 any disclosure of my protected health information (PHI) carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy regulations.

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.

Any person who knowingly presents false information in a life settlement or viatical settlement application contract or agreement may be guilty of a crime and may be subject to fines and confinement in prison.

Authorized Disclosers

Authorized Recipients

Signature of Insured

Printed Name

Date

Signature of Witness

Printed Name

Date



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Authorization for Release of Policy Info

I hereby authorize _____ to release to **Select Life Settlement Corporation** any insurance policy information, including but not limited to, illustrations, forms, riders and amendments concerning the life insurance policy insuring the life of

I understand that Select Life Settlement Corporation will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy on which I am the owner, and I hereby expressly authorize such use and disclosure. I agree that this Authorization shall remain valid for twenty-four (24) months from the date thereof absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under and that a photographic copy or facsimile of this Authorization shall be valid as the original. I understand that I may withdraw the consent of this Authorization under any applicable state statute or regulation.

Signature of Policy Owner

Printed Name Date

Signature of Witness

Printed Name Date