Select Life Settlement Corporation

291 Main Street
Northport, NY 11768
Phone: 631-239-6656
Fax: 631-239-6657
www.selectlife.net

Key Information to evaluate a potential Life Settlement:

- Completed Pre-Qualification 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"
- A signed copy of the "Broker of Record" letter

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.

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Life Settlement Pre-Qualification Worksheet

Prospect Name(s)_____

Agent Name_____

Date_____

General Criteria

❑ Insured over age 65 (both if survivorship)

❑ Policy Face Amount Over $100,000

❑ Insurance Company Rated B+ or Better

❑ 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	

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Life Settlement Application

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

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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

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Primary Insured Medical Information

Brief Description of Insured Medical History and Condition(s)		
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.

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Second Insured Medical Information

Brief Description of Insured Medical History and Condition(s)		
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.

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Have you (or, if survivorship, either of you) ever had any of the following?

❑ Chest Pain/Tightening	❑ Hypertension	❑ Shortness of Breath	❑ TB/Lung Disorder
❑ Heart Attack	❑ Stroke/TIA	❑ Hepatitis	❑ Depression
❑ Digestive Problems	❑ Blood in Stool	❑ Asthma	❑ Arthritis
❑ Dizzy Spells	❑ Cancer	❑ Diabetes	❑ Memory Loss

If any of the above have been checked, please give a description of treatment given, current status, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

If available, please include the following with this application:

- current in-force illustration of life insurance policy(ies) to maturity—with a level death benefit and cash values near zero
- current APS(s) [attending physician statement(s)] within past 90 days

Important Notice: Any person who knowingly presents false information in a life settlement application, contract or agreement is guilty of a crime and may be subject to fines and/or imprisonment.

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Authorization for Disclosure of Protected Health Information (HIPAA Compliant)

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.

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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

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Appointment of

Select Life Settlement Corporation

as Broker of Record

I/We, _____ , hereby appoint **Select Life Settlement Corporation (SLSC)** of 291 Main Street, Northport, NY, 11768, as "Broker of Record" and authorize SLSC to act exclusively on my/our behalf in the matter of the potential sale of Policy # _____, Issued by_____ (life insurance carrier) on _____, _____ (policy issue date) on the life of _____.

I/We also authorize the release of all pertinent information required by SLSC for this purpose, including but not limited to specific information related to policy # _____ and personal medical history and records for all insureds. I/We understand that SLSC will treat this information as highly confidential, but will release this information to one or more licensed Life Settlement Providers for the purpose of securing an offer to purchase Policy # _____

This appointment shall remain effective for a period of 120 days, beginning _____ _____, 20____, or until 30 days after written notice of termination is served by either party.

I/We hereby declare that I/We are the owner(s) of Policy #_____, and that I/we are authorized by the insured(s) to act on their behalf in this matter.

_____ _____

Policy Owner's Signature Policy Owner's Name (Printed)

_____

Name , Date, and TIN of Trust (if applicable)

Dated this _____ day of _____, 20____.

_____

Signature of Witness Date