

GBS Insurance & Financial Services, Inc.

Life Settlement Brokerage Division

Anti-Fraud Policy

Statement of Policy

As part of general operating practice, GBS Insurance & Financial Services, Inc. (hereafter referred to as GBS) will not knowingly contract, or engage in business for, life insurance policies that have been obtained by presenting or concealing materially false factual information for the purpose of misleading another.

We have a Compliance and Anti-Fraud Review team consisting of the chief underwriter and the GBS manager, which is responsible for ensuring that anti-fraud procedures listed herein are implemented at all levels and that deviations from these procedures are formally reported to management. If document inconsistencies or activity indicators are identified, they will be reported to the Compliance and Anti-Fraud Review team as part of standard procedure. The Compliance and Anti-Fraud Review team should, in turn, report to management with a recommendation of action. This action may include, but is not limited to, requesting additional information from the insured's treating physician or other medical providers, and/or the insurance company issuing the policy.

GBS receives information from Member Providers. Member Providers are third parties who have direct access to the customer. GBS only deals with third parties who have adopted anti-fraud policies at least as stringent as its own.

Document Inconsistencies

- Alterations to forms (e.g. erasures, white-out, strikeovers, different type inks and different handwriting);
- Out of date information on viatical/life insurance application. (e.g. old telephone number, former address);
- Mixture of handwriting and typewriting on any documents;
- Dates on life insurance applications that do not coincide with dates in medical records;
- Answers on life insurance application that do not coincide with information found on viatical application or in medical records;
- Inconsistency in statements (applicant, physician, policy owner);
- Altered or incomplete medical records;
- Gross inconsistency in viator signatures;
- Photocopied forms where a typed portion is clearer than the balance of the text;
- Typed, rather than printed, letterheads or no letterheads.
- Lack of physicians' signatures on letter of competency, physician's questionnaire and/or diagnosis date confirmation;
- Altered or incomplete release form for medical records or release of policy information forms
- Activity Indicators
- Disagreement of prognosis by insured's attending physicians;
- Re-submission of an application with new or different data by the same agent or owner of a previously submitted and rejected viatical application.
- The insured moves frequently and/or fails to advise of changing physicians.

Further Action

Employees who identify probable reason to suspect material inconsistencies based on the review of the foregoing items should report such indicators to the Compliance and Anti-Fraud Review team. If the team cannot resolve the material inconsistency, the team will contact the owner of the policy for clarification. Failure to resolve the inconsistency with the owner of the policy should void any proposed transfer on that file and may result in forwarding the file to the applicable state Department of Insurance for further review for possible identification of suspected fraud.

At the close of this review process, additional reviews may be conducted by Member Providers. Such reviews should consist of a complete review of all documents and executed contracts received from the owner and/or the insurance company. If suspected fraud is identified, the Member should immediately suspend any transaction on the file and report the possibility of fraud to the applicable state Department of Insurance with a request for additional guidance.

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Review for Material Inconsistency

The GBS Compliance and Anti-Fraud Review team reviews all forwarded files containing material inconsistencies. The term "material inconsistency" means those items included previously in this document and includes:

A difference between the diagnosis dates reported by the applicant (either verbally or on the application form), reported in applicant's medical record, or as noted in the original insurance application;

A difference between the applicant's medical visitation, hospitalization, or medication records as reported on the application and as set forth on the original insurance application;

Any indication that the applicant has been declined for health insurance or life insurance which is not noted on the original application for insurance; or, a different physician's name reported in the medical records as the attending or treating physician at the time of diagnosis and as reported on the original insurance application.

Disclaimers

"Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison."

Reporting

Suspicious of fraud will be reported to the provider that submitted the case for underwriting assessment. The report of the suspected fraud should include the following:

This form appears to contain material inconsistencies relevant to other documentation we have received.

Please advise us of further action you may wish us to undertake and of any further documentation you may require in our mutual effort to fight fraud. Please also advise us if the above mentioned state provides immunity from civil liability for reporting of and providing documentation of possible viatical fraud.

Any act of suspected fraud will also be referred to the State of Connecticut Insurance Department Consumer Affairs, P.O. Box 816, Hartford, CT 06142-0816. The Consumer Affairs Division requires that concerns or complaints be submitted in writing.

Education and Training

GBS trains their employees to identify material inconsistencies. Underwriters have direct access to appropriate Compliance and Anti-Fraud personnel and are aware of the importance of reporting material inconsistencies in any application documents.

Policy Owner Notification

All unresolved material inconsistencies will be reported to the Member Provider for further review. However, prior to reporting material inconsistencies to the state Department of Insurance, GBS or the Member Provider will ensure that the owner or applicant with whom it has dealt receive written notification of the material inconsistencies.

If the viator responds to the inquiry within a reasonable amount of time with a plausible explanation of the inconsistency and provides documentation supporting the same, the file may be re-opened for processing and no communication will be made to the Department of Insurance.

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Review for Inconsistencies Between Medical Records and Life Insurance Policy Applications

GBS will not “knowingly enter into, broker, or otherwise deal in a Viatical settlement contract the subject of which is a life insurance policy, knowing that the policy was obtained by presenting materially false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator’s agent intended to defraud the policy’s issuer.” GBS has adopted and implemented procedures for identifying and resolving material inconsistencies between medical records and insurance applications.

In the event it is determined that there is a material discrepancy between the records and the insurance policy application, the follow-up actions to research and/or resolve such discrepancy will be fully documented.