

GBS Insurance & Financial Services, Inc.

Life Settlement Questionnaire

PERSONAL DATA:

Name of Insured: _____ Social Security #: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Evening): _____ Cell: _____

Date of Birth: _____ Marital Status: _____ Sex: ___ Male ___ Female

Second (2nd) Insured: _____ Social Security #: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Evening): _____ Cell: _____

Date of Birth: _____ Marital Status: _____ Sex: ___ Male ___ Female

POLICY OWNER (if Different than the Insured):

Name of Policy Owner: _____

Name of Trustee (if owner is a Trust): _____

Social Security / Tax ID#: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Day): _____ Phone (Evening): _____ Cell: _____

If an individual, has the owner ever been divorced: ___ Yes ___ No

If an individual, has the owner ever declared bankruptcy: ___ Yes ___ No

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Life Insurance Policy Information (Please provide for each Policy being offered for sale)

Name of Insurance Company: _____

Policy Number: _____ Policy Issue Date: _____

Face Amount: _____ Cash Surrender Value: _____

Insuring: _____ Individual _____ Survivorship

Type of Policy: _____ Universal _____ Variable _____ Term _____ Whole Life _____ Survivorship _____ Group

If Term Policy, can be converted until what date?: _____

Annual Premium: _____ Paid: _____ Annually _____ Semi-Annually _____ Quarterly _____ Monthly

Date of Last Premium Payment: _____ Amount: _____

Next Premium Due Date: _____

Beneficiary(ies): _____

Primary Beneficiary's Address: _____

City: _____ State: _____ Zip Code: _____

Reason for original Purchase: _____ Estate Planning _____ Family Protection _____ Buy/Sell Agreement

_____ Other (Please Describe): _____

Reason For Selling: _____

Total Face Value of Life Insurance Not Being Offered for Sale Herewith: _____

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- 1 Height: _____ Weight: _____
 2 Please provide a brief description of your medical condition:

- 3 Do you or have you smoked cigarettes, cigars or used tobacco products: Yes No
 In the past 12 months: Yes No Type & Amount used daily: _____
- 4 Do you or have you consumed alcoholic beverages? Yes No
 If yes, frequency of use: Daily Weekly Monthly Occasionally
 Amount consumed on each occasion: _____
 Any treatment for alcohol use (including AA treatment): Yes No
- 5 Do you or have you had any following disease or disorder of the heart? (Please specify which below)
 Heart attack: _____ Pacemaker: _____ Heart valve surgery: _____
 Atrial fibrillation: _____ Heart bypass surgery or angioplasty: _____
- 6 Do you have any of the following neurologic conditions?
 Stroke: Yes No If YES, number of episodes? _____
 Transient Ischemic Attack (TIA): Yes No If YES, number of episodes? _____
- 7 Do you have Diabetes: Yes No If YES: Type I (insulin) Type II (non-insulin)
- 8 Do you currently have or have previously had any type of cancer: Yes No
 If YES, how many years ago were you first diagnosed? _____

List ALL Physicians Seen in the last 5 years			
Doctor's Name:		Doctor's Name:	
Clinic:		Clinic:	
Address:		Address:	
Phone:		Phone:	
Specialty:		Specialty:	
For how long?:	Date & Reason for last visit:	For how long?:	Date & Reason for last visit:
Doctor's Name:		Doctor's Name:	
Clinic:		Clinic:	
Address:		Address:	
Phone:		Phone:	
Specialty:		Specialty:	
For how long?:	Date & Reason for last visit:	For how long?:	Date & Reason for last visit:

***Please attach a separate page for additional doctors**

GBS Insurance & Financial Services, Inc.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider, health care clearinghouse and healthcare plan (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. 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 (a) GBS Insurance & Financial Services, Inc., (b) any viatical/life settlement provider, (c) any person who may seek to purchase any life insurance policy insuring my life or other insurance product I own, (d) any financing entity of a viatical/life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (e) any life expectancy provider, (f) any life insurance company that has issued a life insurance policy insuring my life, and (g) any of the respective affiliates, agents, employees, representatives, advisors, successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (a) through (f), inclusive (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, including information relating to psychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) 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 any Authorized Recipient and (b) 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 any Authorized Recipient purchases.
4. Expiration of Authorization. This authorization shall remain valid until, and shall expire, two (2) years from the date hereof.
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. I understand that no Authorized 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 HIPAA (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

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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.

INSURED:

Signature

Print Full Name

_____, 20_____
Date

WITNESS:

Signature

Print Full Name

_____, 20_____
Date

GBS Insurance & Financial Services, Inc.

Authorization to Release Insurance Information:

I hereby authorize my insurance company to furnish, **GBS Insurance & Financial Services, Inc.**, or its authorized representatives any information and forms they may request in connection to my policy, (including any conversions thereof or replacements therefore). I agree that a photo static copy or facsimile of this Authorization shall remain valid for 4 (four years), absent any provision of any applicable state statute or regulation to the contrary, in which event this authorization shall remain valid for the maximum period permitted there under. I understand that all information will be kept strictly confidential.

Name of Insurance Company: _____ Policy #: _____

Address: _____

(City)

(State)

(Zip Code)

Name of Insured: _____

Signature of Insured: _____ Date: _____

Name of Second Insured: _____

Signature of Second Insured: _____ Date: _____

Name of Owner (If other than the Insured): _____

Signature of Owner (If other than the Insured): _____ Date: _____

Name of Witness: _____

Signature of Witness: _____ Date: _____

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Broker of Record Letter For Life Settlements

I, _____, Owner of policy number _____,
with _____ Insurance Company, have agreed to consider the
sale of this policy as a Life Settlement.

My broker of record for the sale of the above mentioned policy is GBS Insurance & Financial Services, Inc..

Signature of Owner: _____ Date: _____

Print Name of Owner: _____

Address: _____

(City) (State) (Zip Code)

Signature of Witness: _____ Date: _____

Print Name of Witness: _____

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Disclosure Notice to Owner:

1. There are possible alternatives to life settlement contracts/selling your life insurance. This may include the option of an accelerated death benefit or policy loans offered by your life insurance company. You are advised to consult a financial advisor, certified public accountant or an attorney regarding these potential alternatives.
2. GBS Insurance & Financial Services, Inc., a broker, represents exclusively the owner and not the insurer or the provider, and, if required by State law, owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.
3. Some or all of the proceeds of the life settlement may be taxable under federal income tax and/or state franchise and income tax laws. You should consult a professional tax advisor.
4. Life settlement proceeds could be subject to the claims of creditors.
5. Receipt of the proceeds of a life settlement may affect your right to receive Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
6. The owner has a right to rescind the life settlement contract within fifteen days of the date it is executed by all parties and the owner has received the disclosures contained herein. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.
7. Proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated in accordance with the life settlement contract.
8. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the owner. Assistance should be sought from a financial advisor.
9. Disclosure to an owner shall include distribution of a brochure or Buyer's Guide during the solicitation process describing life settlements. The NAIC's form for the brochure shall be used unless another form is developed or approved by the commissioner.
10. All medical, financial or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement between the owner and the 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. You may be asked to renew your permission to share information every two years.
11. Following the execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided under state law. This contact may be limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less. All such contacts shall be made only by a life settlement provider licensed in the state in which the policy owner resided at the time of the life settlement, or by the authorized representative of a duly licensed life settlement provider.

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12. The name, business address, and telephone number of GBS Insurance & Financial Services, Inc., a life settlement broker, is 2228 Black Rock Tpke, Suite 301, Fairfield, CT, phone: (800) 653-1322.

13. GBS Insurance & Financial Services, Inc., a broker, shall submit to you and your life insurance producer (if any), a full, complete, and accurate description of all offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract.

14. GBS Insurance & Financial Services, Inc., a broker, will provide the owner with a written disclosure of any affiliations or contractual arrangements between GBS Insurance & Financial Services, Inc. and any person making an offer in connection with the proposed life settlement contract.

15. GBS Insurance & Financial Services, Inc., a broker, will be compensated. The provider, not the owner, will compensate GBS Insurance & Financial Services, Inc. based on a formula that is a percentage of the offer obtained (the amount and method of calculating the compensation paid). Compensation can include, but is not limited to, bonuses, expense reimbursement, overrides or other funds in addition to broker commissions.

16. GBS Insurance & Financial Services, Inc. shall disclose the name of each broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract.

17. GBS Insurance & Financial Services, Inc. shall provide a complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For purposes of this paragraph, "gross offer" or "bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees. Failure to provide the disclosures or rights described in this section shall be deemed an unfair trade practice.

Owner's signature: _____ **Date:** _____

Type or Print Owners Name: _____ **SS # / Tax ID#:** _____

Insured's signature: _____ **Date:** _____

Type or Print Insured's Name: _____ **SS #:** _____

GBS Insurance & Financial Services, Inc.

Agent Checklist for Application Package

This checklist was designed to help you ascertain if you have completed all pertinent items in order to expedite the processing of the Life Settlement application. GBS Insurance & Financial Services, Inc. must receive the following items in order for the policy to be processed:

- Application must be filled out completely and signed. Anything that is not applicable, mark N/A". If more than one policy, make additional copies of pages 2, 7 and 8.
- The release forms for Medical and Policy Information must be signed and dated by the appropriate parties as indicated. Please make additional copies as needed.
- The "Notice of Disclosure", must be signed and dated.
- Broker of Record Letter must be signed and dated.

*The items listed below will be needed for closing and some buyers will require these items before they will issue closing documents. Please begin to collect these items now if they are not currently available:

- Insured's Photo ID. Accepted forms of identification are photocopies of a driver's license or passport. Identification must be current, not expired.
- Complete copy of the Insurance Policy or Policies. If this is not immediately available, please make a note for us on the application and forward as soon as possible.
- If Owner/Beneficiary is a Trust, we need:
 - o Copy of Trust and Tax ID#
 - o Trustee(s) must sign the policy information release form
- If Owner/Beneficiary is a Corporation, we need:
 - o Complete name and address of the Corporation
 - o Corporate resolution showing current authorized Officers
 - o Two Officers must sign the policy information release form

Representing Agent: _____

Address: _____

(City) (State) (Zip Code)

(Telephone/Daytime) (Fax) (Cell)

Agents Signature: _____ Date: _____