Life Plans/GBS Insurance

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

Life Plans/GBS Insurance

<u>Life Insurance Policy Information</u> **(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:_____________________________

Life Plans/GBS Insurance

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?:	For how long?:
Date & Reason for last visit:	Date & Reason for last visit:

Doctor's Name:	**Doctor's Name:**
Clinic:	Clinic:
Address:	Address:
Phone:	Phone:
Specialty:	Specialty:
For how long?:	For how long?:
Date & Reason for last visit:	Date & Reason for last visit:

Doctor's Name:	**Doctor's Name:**
Clinic:	Clinic:
Address:	Address:
Phone:	Phone:
Specialty:	Specialty:
For how long?:	For how long?:
Date & Reason for last visit:	Date & Reason for last visit:

Life Plans/GBS Insurance

Life Settlement Medical Questionnaire

1 Height: Weight:

2 Please provide a brief description of your medical condition:

3

Family History	Current Age	Deceased	If deceased, cause & age
Father		___Yes ___No	
Mother		___Yes ___No	
Brother/Sister		___Yes ___No	
Brother/Sister		___Yes ___No	
Brother/Sister		___Yes ___No	

4 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: ______________________________

5 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

6 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:

7 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?

8 Do you have Diabetes: ___Yes ___No If YES: ___ Type I (insulin) ___ Type II (non-insulin)

9 Do you currently have or have previously had any type of cancer: ___Yes ___No
If YES, how many years ago were you first diagnosed?

10 Do you have any of the following diseases of the brain or nervous system: ___Yes ___No

Disease	Answer	Cognitive	Physical
Parkinson's	___Yes ___No		
Alzheimer's	___Yes ___No		
ALS*	___Yes ___No		
MS**	___Yes ___No		

*Amyotrophic Lateral Sclerosis (ALS), often referred to as "Lou Gehrig's disease," is a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord.
**Multiple Sclerosis (MS) is an autoimmune disease that affects the central nervous system (CNS). The CNS consists of the brain, spinal cord, and the optic nerves. Surrounding and protecting the nerve fibers of the CNS is a fatty tissue called Myelin, which helps nerve fibers conduct electrical impulses.

Life Plans/GBS Insurance

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) Life Plans/GBS Insurance, (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 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

Life Plans/GBS Insurance

Authorization to Release Insurance Information:

I hereby authorize my insurance company to furnish, **Life Plans/GBS Insurance**, 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 statue 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:___________

Life Plans/GBS Insurance

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 Life Plans/GBS Insurance.

Signature of Owner: ____Date:________________

Print Name of Owner: ____

Address: ____

____

(City) (State) (Zip Code)

Signature of Witness: ____Date:_________________

Print Name of Witness: ____

Life Plans/GBS Insurance

Notice of Disclosure:

1. There may be alternatives to a Life Settlement contract, including, but not limited to, accelerated benefits, loans secured by the policy, and surrender of the policy for cash value offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. We encourage you to contact the issuer of your policy to discuss these other benefits.
2. Some or all of the proceeds of your Life Settlement may be taxable under federal income tax and/or state franchise and income tax laws. Life Plans/GBS Insurance strongly encourages you to consult your own attorney or tax advisor concerning this transaction. Life Plans/GBS Insurance makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of your Life Settlement proceeds may adversely affect your eligibility for social security income, public assistance, public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Proceeds from a Life Settlement may not be exempt from claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents or others, there may be a loss of coverage. We urge you to contact the issuer of your life insurance policy for information on these provisions.
6. Entering into a Life Settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other right or benefits, including conversion rights and waiver of premium benefits that may exist under the policy to be forfeited by you.
7. All medical, financial or personal information solicited or obtained by Life Plans/GBS Insurance about the 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 Life Settlement between you and Life Plans/GBS Insurance. If the insured is asked to provide this information, the insured will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. The insured may be asked to renew his or her permission to share information every two years.
8. The insured may be contacted by Life Plans/GBS Insurance or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months.
9. Funds will be sent to you within three (3) business days after Life Plans/GBS Insurance has received the insurers or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
10. You have the right to rescind a Life Settlement contract for a period of (15) calendar days after your receipt of the proceeds. If the insured dies during the rescission period the settlement shall be deemed rescinded.
11. You are encouraged to contact an attorney, accountant, financial planning advisor, insurer, tax advisor or social services agency regarding potential consequences resulting from entering into a Life Settlement.

Owner's signature: ______________________________________ Date: ____________________________

Type or Print Owners Name: ________________________________ SS # / Tax ID#:___________________

Insured's signature: _____________________________________ Date:____________________________

Type or Print Insured's Name: ______________________________ SS #:___________________________

Life Plans/GBS Insurance

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. Life Plans/GBS Insurance 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.

□ Agent 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 price a case. 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:_______________