

CASE SUBMISSION FORMS
CASE GUIDELINES

1. Life Expectancy or Age of the Insured?

- Life expectancy must **NOT** exceed 12 years at any age.
- Target minimum age – Male: 75+ , and, Female: 78+
- Health conditions **must** exist at **and** below target minimums ages.

2. Face Value?

- **Aggregate of \$500,000 per insured preferred, or,**
- **Minimum of \$250,000 and upwards.**

3. Premium Payments?

- **Premiums must continue to be paid.**
- **Policy(s) MUST still be in force at all times.**

4. Medical Records and the Agent?

- Insured or Agent can order Medical Records directly themselves, and, with local follow-up, time will be saved. Often if the Insured places the order, no cost is involved.
- Please still enclose the Authorization with the Case Submission package and forward to the Contact.

5. Medical Records and Inforce Ledgers?

- Do not wait for the Medical Records or Inforce Ledgers to arrive in order to send all the documentation together.
- If you have the Authorization for the Release of Medical, and, Authorization for the Release of Insurance Information, and, the Viatical Settlement and Life Settlement Application completed, please forward them immediately. The rest of the documentation may be forwarded when available

6. New Issues or Wet Ink Policies, and, Contestable Policies?

- New Issues or Wet Ink Policies are not acceptable for submission.
- Policies in force for one year, although contestable, will be accepted on a case by case basis.
- Genuine circumstances and reasons as to the purpose of the submission must accompany contestable Policies.
- Term Conversions – Policy is in force from the original Policy Issue date of the Term Product.

7. Broker of Record Form

- To be completed by the Policy Owner.

8. Physician's Letter of Competency (LOC)

- Insured – To be forwarded to Primary or Family Physician by Fax or Mail

9. Required Notice for Client – LEAVE WITH CLIENT

10. Acknowledgment by Agent or Agent's Representative

- To be completed by Agent or Agent's Representative
- This form replaces direct witnessing of insured and policy owner signatures, as often this may not be practical as a witness may not be available.

LIFE SETTLEMENT APPLICATION
CHECKLIST FOR SUBMITTING THE APPLICATION

CHECK **PLEASE COMPLETE AND FORWARD ALL FORMS**

- _____ **Life Settlement Application**
- _____ **Broker of Record Form**
- _____ **Authorization for the Release of Medical Information**
- _____ **Authorization for the Release of Insurance Information**
- _____ **Physician's Letter of Competency for EACH insured – Forward to Physician**
- _____ **Acknowledgement by Agent or Agent's Representative**
- _____ **Medical Records on file in order to show health history – Last 2 years**
- _____ **Copy of Policy – Policy Specification pages and Standard Provisions of the contract**
- _____ **Copy of Trust Documents – *if applicable*.**
- _____ **Required Notice – This document must be left with the Client.**
- _____ **COPY OF ALL FORMS FORWARDED TO POLICY OWNER/INSURED**

INFORCE LEDGERS – PLEASE FORWARD WITH LIFE SETTLEMENT APPLICATION

****If not available, do not wait for the Inforce Ledgers – they can be faxed on receipt.****

1. *Universal Life*

Illustrations run, with Death Benefit and Premiums LEVEL, to solve for \$1 cash value at Current Assumptions:

- _____ To Maturity – The Policy should state what the Maturity Age is.
- _____ Life Expectancy – 21st Services Median LE, if available, AND,
- _____ Life Expectancy – 21st Services Median LE, PLUS ONE (1) years, AND,
- _____ Life Expectancy – 21st Services Median LE, PLUS TWO (2) years.

Main goals are to have minimum premiums paid, reduce loans, and, minimize cash value

2. *Term Life*

- _____ Illustration run to the end of the term showing current premium schedule.
- _____ Term Conversion illustration to Universal Life (see section 1).

3. *Whole Life*

Illustrations run with Death Benefit and Premiums LEVEL, AND,

- _____ Run at natural vanish premium, AND,
- _____ Dividends reducing premium and excess to loans and/or cash value, AND/OR,
- _____ Surrender of paid up additions to reduce cash value, premium and/or loan.

Main goals are to have minimum premiums paid, reduce loans, and, minimize cash value

4. *Variable Universal Life*

Illustrations run, with Death Benefit and Premiums LEVEL , to solve for \$1 cash value at maturity AND,

- _____ Run at a Fixed Account Rate, and/or,
- _____ Money Market Rate
- _____ To Maturity – The Policy should state what the Maturity Age is.
- _____ Life Expectancy – 21st Services Median LE, if available, AND,
- _____ Life Expectancy – 21st Services Median LE, PLUS ONE (1) years, AND,
- _____ Life Expectancy – 21st Services Median LE, PLUS TWO (2) years.

Main goals are to have minimum premiums paid, reduce loans, and, minimize cash value

LIFE SETTLEMENT APPLICATION
COMPRISING OF SECTIONS 1 THROUGH 5

SECTION 1 OF 5 – PERSONAL INFORMATION

First Insured Name _____ Sex: Male () Female ()
First Insured Date of Birth _____ Social Security Number _____
Second Insured Name _____ Sex: Male () Female ()
Second Insured Date of Birth _____ Social Security Number _____
Address _____
City _____ State _____ ZIP _____
Marital Status: Single () Married () Divorced () Widowed () Currently Employed: Yes () No ()
Have you been or are you a party to: Civil Suit? () Bankruptcy? () Judgements? () Credit Liens? () Tax Liens? ()

SECTION 2 OF 5 - LIFE INSURANCE POLICY INFORMATION

POLICY # 1 **INSURED:** **FIRST () SECOND () BOTH () – SECOND TO DIE**

Insurance Company: _____
Policy #: _____ Policy Issue Date: _____ Contestability Period: _____ Yrs
Face Value: \$ _____ + Paid Up Additions: \$ _____ = Death Benefit: \$ _____
Cash/Account Surrender Value: \$ _____ Policy Loan: \$ _____ Maturity Date: _____
Annual Premium Payment: \$ _____ Premium?: To Maturity () For _____ years ()
Type of Policy? Term () Whole Life () Universal Life () Other? _____
Policy Owner?: Insured () Other () If other, please complete following:-
Trust/Corp/Individual Name: _____ State: _____
SS#/TIN# _____ Trustee/Contact Name: _____
Beneficiary?: Policy Owner - Yes () No () If No, who is the Beneficiary? _____

POLICY # 2 **INSURED:** **FIRST () SECOND () BOTH () – SECOND TO DIE**

Insurance Company: _____
Policy #: _____ Policy Issue Date: _____ Contestability Period: _____ Yrs
Face Value: \$ _____ + Paid Up Additions: \$ _____ = Death Benefit: \$ _____
Cash/Account Surrender Value: \$ _____ Policy Loan: \$ _____ Maturity Date: _____
Annual Premium Payment: \$ _____ Premium?: To Maturity () For _____ years ()
Type of Policy? Term () Whole Life () Universal Life () Other? _____
Policy Owner?: Insured () Other () If other, please complete following:-
Trust/Corp/Individual Name: _____ State: _____
SS#/TIN# _____ Trustee/Contact Name: _____
Beneficiary?: Policy Owner - Yes () No () If No, who is the Beneficiary? _____

POLICY # 3 **INSURED:** **FIRST ()** **SECOND ()** **BOTH () – SECOND TO DIE**

Insurance Company: _____
Policy #: _____ Policy Issue Date: _____ Contestability Period: _____ Yrs
Face Value: \$ _____ + Paid Up Additions: \$ _____ = Death Benefit: \$ _____
Cash/Account Surrender Value: \$ _____ Policy Loan: \$ _____ Maturity Date: _____
Annual Premium Payment: \$ _____ Premium?: To Maturity () For _____ years ()
Type of Policy? Term () Whole Life () Universal Life () Other? _____
Policy Owner?: Insured () Other () If other, please complete following:-
Trust/Corp/Individual Name: _____ State: _____
SS#/TIN# _____ Trustee/Contact Name: _____
Beneficiary?: Policy Owner - Yes () No () If No, who is the Beneficiary? _____

POLICY # 4 **INSURED:** **FIRST ()** **SECOND ()** **BOTH () – SECOND TO DIE**

Insurance Company: _____
Policy #: _____ Policy Issue Date: _____ Contestability Period: _____ Yrs
Face Value: \$ _____ + Paid Up Additions: \$ _____ = Death Benefit: \$ _____
Cash/Account Surrender Value: \$ _____ Policy Loan: \$ _____ Maturity Date: _____
Annual Premium Payment: \$ _____ Premium?: To Maturity () For _____ years ()
Type of Policy? Term () Whole Life () Universal Life () Other? _____
Policy Owner?: Insured () Other () If other, please complete following:-
Trust/Corp/Individual Name: _____ State: _____
SS#/TIN# _____ Trustee/Contact Name: _____
Beneficiary?: Policy Owner - Yes () No () If No, who is the Beneficiary? _____

POLICY # 5 **INSURED:** **FIRST ()** **SECOND ()** **BOTH () – SECOND TO DIE**

Insurance Company: _____
Policy #: _____ Policy Issue Date: _____ Contestability Period: _____ Yrs
Face Value: \$ _____ + Paid Up Additions: \$ _____ = Death Benefit: \$ _____
Cash/Account Surrender Value: \$ _____ Policy Loan: \$ _____ Maturity Date: _____
Annual Premium Payment: \$ _____ Premium?: To Maturity () For _____ years ()
Type of Policy? Term () Whole Life () Universal Life () Other? _____
Policy Owner?: Insured () Other () If other, please complete following:-
Trust/Corp/Individual Name: _____ State: _____
SS#/TIN# _____ Trustee/Contact Name: _____
Beneficiary?: Policy Owner - Yes () No () If No, who is the Beneficiary? _____

SECTION 3 OF 5 – MEDICAL INFORMATION – FIRST INSURED

This summary is used for cross checking with the medical records to ensure that we have all necessary information.

FIRST INSURED NAME: _____ **SS#** _____

Has insured smoked: Cigarettes _____ Cigars _____ Cigarillos _____ Pipe _____ in the past 12 months No _____

Does insured use or has ever used alcoholic beverages? Yes _____ No _____ If yes, please answer the following:

Frequency of use? Daily _____ Weekly _____ Monthly _____ Occasionally _____

Amount consumed on each occasion: _____

Any treatment for alcohol use (including AA treatment)? _____

FAMILY HISTORY **Current Age** **Deceased?** **If deceased, cause and age at time of death?**

Father _____ Yes _____ No _____ _____

Mother _____ Yes _____ No _____ _____

Brother/Sister _____ Yes _____ No _____ _____

Brother/Sister _____ Yes _____ No _____ _____

Present Table Rating _____ Medical Condition _____

Name of Primary Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

SECTION 4 OF 5 - MEDICAL INFORMATION - SECOND INSURED

This summary is used for cross checking with the medical records to ensure that we have all necessary information.

SECOND INSURED NAME: _____ **SS#** _____

Has insured smoked: Cigarettes _____ Cigars _____ Cigarillos _____ Pipe _____ in the past 12 months No _____

Does insured use or has ever used alcoholic beverages? Yes _____ No _____ If yes, please answer the following:

Frequency of use? Daily _____ Weekly _____ Monthly _____ Occasionally _____

Amount consumed on each occasion: _____

Any treatment for alcohol use (including AA treatment)? _____

FAMILY HISTORY	Current Age	Deceased?	If deceased, cause and age at time of death?
Father	_____	Yes _____ No _____	_____
Mother	_____	Yes _____ No _____	_____
Brother/Sister	_____	Yes _____ No _____	_____
Brother/Sister	_____	Yes _____ No _____	_____

Present Table Rating _____ Medical Condition _____

Name of Primary Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

Name of Specialist Physician _____ **Medicals \$** _____

Medical Facility: _____

Address _____

Tel: (_____) _____ Fax: (_____) _____ email _____

SECTION 5 OF 5 – PERSONAL ACKNOWLEDGEMENT

You understand, consent to, and represent the following:

- 5.1 The policy or policies are being submitted with this Application because you are (i) purchasing a new policy, (ii) obtaining additional cash proceeds to use as you deem necessary for your personal use, (iii) no longer in need of or desire, life insurance, (iv) effectuating changes in your estate, family, business, investment or financial planning matters, or (v) Other:
-
- and the policy or policies are therefore considered to be unwanted and/or unnecessary.
- 5.2 Acceptance of this Application does not in any way constitute or guarantee the purchase of life insurance policies as detailed in this Application. This Application is not a contract for the sale of your policy. The information contained within may be used for evaluation purposes only to determine whether you may be able to sell your policy. The information contained within may be used for evaluation purposes only. Any information obtained may be used or disclosed to other parties for qualification purposes in order to effect or facilitate the settlement transaction. Confidential information will not otherwise be disclosed to any person without your prior written consent.
- 5.3 The purpose of this Application is to procure a settlement offer on a policy or policies referred to in this Application.
- 5.4 The source of funds for any settlement offer may include institutional, commercial, corporate, private and/or individual investors, purchasers, funders and/or providers that conduct business on a local, state or national level.
- 5.5 Other rights and benefits, such as disability benefits, conversions or particular riders on the policy(s) detailed in this Application, may exist under the policy(s) and may be forfeited by the life settlement. The insurance carrier should be contacted for additional information.
- 5.6 You may incur tax consequences by entering into a life settlement. Assistance should be sought from a professional tax advisor. The tax information relayed to you is not meant to be tax advice, and, consultation with your professional tax advisor is necessary.
- 5.7 Proceeds of the life settlement could be subject to the claims of creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.
- 5.8 Receipt of the proceeds of a life settlement may adversely affect eligibility for supplemental social security income, Medicaid or other Government benefits or entitlements. The appropriate Government agencies should be consulted for advice.
- 5.9 Seniors and individuals with a catastrophic or life-threatening illness or condition may qualify for a Viatical Settlement should the life expectancy of the insured named in the policy(s) be 24 months or less. Professional advisors should be contacted and consulted for further advice.
- 5.10 You may have alternatives to a life settlement that are provided in relation to the policy, such as accelerated benefits, policy loans and surrender of the policy's cash value. You should review the terms of your policy to determine which options are available to you.
- 5.11 If the subject policy is a joint policy or insures the life of another person, a life settlement may result in a loss of coverage.
- 5.12 The purchaser of the subject policy, whether an institution or a private party, has the right to assign or otherwise transfer its interest in the policy to a third party at any time. **YOU ACKNOWLEDGE THAT, THE PURCHASER, OR, IN THE EVENT THAT THE PURCHASER SUBSEQUENTLY ASSIGNS THE SUBJECT POLICY TO A THIRD PARTY, THE THIRD PARTY, MAY, WHETHER KNOWINGLY OR UNKNOWINGLY, OBTAIN YOUR IDENTITY AND YOUR CONTACT INFORMATION, INCLUDING, BUT NOT LIMITED TO, YOUR ADDRESS, PHONE NUMBER AND/OR SOCIAL SECURITY NUMBER, ALTHOUGH LEGAL SAFEGUARDS MAY HAVE BEEN IMPLEMENTED BY STATE LAW TO PREVENT SUCH DISCLOSURE.**

5.23 You acknowledge that you have read and understand the contents of this Application and the attached '**Required Notice – Important information you need to know before entering a Viatical Settlement or Life Settlement**', and, you represent and warrant that all of the information provided in this Application including personal, policy and medical information is true and correct to the best of your knowledge. You acknowledge and agree that you will be liable for any errors or omissions in your responses to the Application and that all information will be relied upon in determining whether your policy is suitable for sale.

I have read and understood the above representations.

INSURED

DATE: _____

X _____
Signature of the **FIRST** Insured

X _____
Signature of the **SECOND** Insured

Name of the **FIRST** Insured

Name of the **SECOND** Insured

Date of Birth

Date of Birth

Social Security Number

Social Security Number

Driver's License – State & Number

Driver's License – State & Number

POLICY OWNER – If other than Insured

DATE: _____

Name of Policyowner – Entity/Corp/Trust *if other than Insured* with Tax ID Number

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

INSURED & POLICY OWNER
BROKER OF RECORD FORM

TO WHOM IT MAY CONCERN

I/We the undersigned appoint Wealth Increase Network, L.P. and any of its successors and assigns and affiliate entities as the exclusive Broker of Record for the Policy(s) listed below for the purpose of negotiating the sale of the Policy(s) as a Life Settlement and the undersigned agrees not to appoint any other individual or entity as a broker of record with respect to the Policy(s) without first revoking this Broker of Record Form by written notice to Wealth Increase Network, L.P.. All Broker of Record forms signed by me/us prior to the date of this Broker of Record form are null and void. I/We agree that a photographic copy or facsimile of this Broker of Record Form shall be valid as the original.

INSURED

DATE: _____

X _____
Signature of the **FIRST** Insured

X _____
Signature of the **SECOND** Insured

Name of the **FIRST** Insured

Name of the **SECOND** Insured

Date of Birth

Date of Birth

Social Security Number

Social Security Number

Driver's License – State & Number

Driver's License – State & Number

POLICY OWNER – If other than Insured

DATE: _____

Name of Policyowner – Entity/Corp/Trust *if other than Insured* with Tax ID Number

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

Insured Name(s): _____

First Insured

Second Insured

Policy Number:

Insurance Company:

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
(HIPAA COMPLIANT)

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, or any other institution or person ("Authorized Discloser")

to provide _____ or its designee ("Authorized Recipient"), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me (hereinafter, "Protected Health Information" or "PHI").

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 treatment of the patient, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the patient, along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in the possession and control of the Authorized Discloser.

By signing below, I understand that this Authorization shall apply to any and all PHI, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I further understand that PHI obtained may be used to evaluate eligibility to participate in Purchaser's life settlement program and to evaluate life expectancy now and in the future. Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this Authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. I further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters.

I understand that I may revoke this Authorization any time with respect to Authorized Recipient or any Authorized Discloser by notifying Authorized Recipient or any such Authorized Discloser of the revocation in writing and delivering such revocation by certified mail or personal delivery at such address designated by Authorized Recipient or any Authorized Discloser.

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"), and that PHI obtained by this Authorization, if redisclosed by authorized Designee, may no longer be protected by the HIPAA Privacy Regulations.

FIRST INSURED

DATE: _____

X _____
Signature of the FIRST Insured

Name of the FIRST Insured

Date of Birth

Social Security Number

Driver's License - State

Driver's License - Number

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION
(HIPAA COMPLIANT)

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, or any other institution or person ("Authorized Discloser")

to provide _____ or its designee ("Authorized Recipient"), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me (hereinafter, "Protected Health Information" or "PHI").

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 treatment of the patient, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the patient, along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in the possession and control of the Authorized Discloser.

By signing below, I understand that this Authorization shall apply to any and all PHI, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I further understand that PHI obtained may be used to evaluate eligibility to participate in Purchaser's life settlement program and to evaluate life expectancy now and in the future. Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this Authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. I further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters.

I understand that I may revoke this Authorization any time with respect to Authorized Recipient or any Authorized Discloser by notifying Authorized Recipient or any such Authorized Discloser of the revocation in writing and delivering such revocation by certified mail or personal delivery at such address designated by Authorized Recipient or any Authorized Discloser.

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"), and that PHI obtained by this Authorization, if redisclosed by authorized Designee, may no longer be protected by the HIPAA Privacy Regulations.

SECOND INSURED

DATE: _____

X _____
Signature of the SECOND Insured

Name of the SECOND Insured

Date of Birth

Social Security Number

Driver's License - State

Driver's License - Number

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I hereby authorize _____ ,
the issuer of Policy Number _____
and/or Certificate Number _____
owned by _____
and insuring the life of _____
to release to _____
all information about the above referenced policy including, but not limited to, the following upon its request: a copy of the policy including the application for insurance, forms, riders, amendments, policy illustrations, annual statements, premium information and verification of coverage.

This Authorization will remain in force until the earlier of: (1) one year from the date signed; (2) consideration of my application has been completed; or (3) it is withdrawn by me pursuant to applicable law. I further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original.

FIRST INSURED

DATE: _____

X _____
Signature of the FIRST Insured

Name of the FIRST Insured

POLICY OWNER – If other than Insured

DATE: _____

Name of Policyowner – Entity/Corp/Trust *if other than Insured* with Tax ID Number

X _____
Authorized Signature of Policyowner *if other than Insured*

Name of Signatory

Title/Relationship of Signatory *if other than Insured*

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Name of Signatory

Title/Relationship of Signatory *if other than Insured*

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Name of Signatory

Title/Relationship of Signatory *if other than Insured*

Driver's License – Number & State

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I hereby authorize _____ ,

the issuer of Policy Number _____

and/or Certificate Number _____

owned by _____

and insuring the life of _____

to release to _____
all information about the above referenced policy including, but not limited to, the following upon its request: a copy of the policy including the application for insurance, forms, riders, amendments, policy illustrations, annual statements, premium information and verification of coverage.

This Authorization will remain in force until the earlier of: (1) one year from the date signed; (2) consideration of my application has been completed; or (3) it is withdrawn by me pursuant to applicable law. I further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original.

SECOND INSURED

DATE: _____

X _____
Signature of the SECOND Insured

Name of the SECOND Insured

POLICY OWNER – If other than Insured

DATE: _____

Name of Policyowner – Entity/Corp/Trust *if other than Insured* with Tax ID Number

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

X _____
Authorized Signature of Policyowner *if other than Insured*

Title/Relationship of Signatory *if other than Insured*

Name of Signatory

Driver's License – Number & State

PHYSICIAN'S LETTER OF COMPETENCY

Patient Name : _____

DOB: _____

SSN#: _____

In your opinion, is this Patient of sound mind and under no constraint or undue influences and able to conduct their own affairs? Yes () No ()

If No, please state your reasons why:

Physician's Signature: **X** _____ **X** Date: _____

Physician's Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Telephone: _____

PLACE }
DOCTOR'S }
STAMP }
HERE } _____

Thank you for completing this form.

PHYSICIAN'S LETTER OF COMPETENCY

Patient Name : _____

DOB: _____

SSN#: _____

In your opinion, is this Patient of sound mind and under no constraint or undue influences and able to conduct their own affairs? Yes () No ()

If No, please state your reasons why:

Physician's Signature: **X** _____ **X** Date: _____

Physician's Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Telephone: _____

PLACE }
DOCTOR'S }
STAMP }
HERE } _____

Thank you for completing this form.

REQUIRED NOTICE FOR CLIENT

IMPORTANT INFORMATION YOU NEED TO KNOW BEFORE ENTERING A LIFE SETTLEMENT

What are life settlements?

A life settlement is the sale of a life insurance policy or certificate (hereafter referred to as policy) issued on the life of a person, who does not have a catastrophic or lifethreatening illness or condition that is likely to result in death within 24 months, for a dollar amount that is less than the policy's face value. The person who is insured under the policy is called a life settlor. This person may or may not be the owner of the policy. Only the owner of the policy has the right to sell the policy. If you do not own the policy, the owner cannot sell the policy without your consent. The entity that buys the policy is called a life settlement provider (hereafter referred to as provider). Additionally, there are persons called brokers or provider representatives, who help with the sale of the policy.

A life settlement offers you the opportunity to receive a portion of your policy's death benefit while you are still alive.

How do life settlements work?

Most providers, provider representatives, or brokers will ask you to complete an application and medical release forms so that they can gather information from your life insurance company and your doctors. All information gathered must be kept confidential and cannot be given to anyone without your written approval. If you qualify, the provider will make you an offer for your policy. The amount offered for your policy will be based on facts such as how long you are expected to live, the amount you pay for premiums, the rating of your insurance company, and your policy's provisions (e.g., a waiver of premium). If you accept the offer, you will be asked to sign a life settlement contract.

Do I have to sell all of my policy?

No. You can sell all of your policy or you can sell only a part of your policy. If you sell only a part, you will be required to assign or transfer only the part being sold. If you sell the entire policy, the provider will become the new owner of the policy.

Is there a difference between a broker and a provider representative?

Yes. Although both a broker and a provider representative will help you with the sale of your policy, there are important differences between them. A broker works for you. A broker will check with several providers to find the best offer for you. A provider representative works for a provider. A provider representative will only check with the provider that he or she works with to get you their offer. If you use someone to help with the sale of your policy, you may want to ask whether they are a broker or a provider representative.

Is the provider, provider representative, or broker required to keep my information confidential?

Yes, any financial, medical, or personal information obtained by a provider, provider representative, or broker about you, including your family members, a spouse, or a significant other, may not be shared with anyone unless you have given written approval that the information may be shared. Any written approval for the sharing of this information must show who may get the information and why it will be released.

If I enter a life settlement contract, when will I get my money and who from?

The answer to this question depends on how the provider runs its business. Some providers use an escrow agent or trustee to handle the money that will be paid to you. If an escrow agent or trustee is used, the escrow agent or trustee will send you the money within three business days of the date the insurance company confirms to the provider that the transfer of ownership has been completed. If an escrow agent or trustee is not used, the provider will send you the money within three business days from the date you signed both the contract and the papers needed to transfer or assign your policy to them.

What if I change my mind?

If you change your mind about selling your policy, you can cancel the life settlement contract at any time up to the 15th day after you receive the money from the provider. To cancel the life settlement contract, you will have to return any money the provider paid to you for the purchase of your policy along with any premiums the provider paid to keep the policy in force. If you change your mind, remember to arrange with the provider to have the insurance company transfer the ownership of the policy back to you.

What if I die shortly after selling my policy?

If you die at any time up to the 15th day after you receive the money from the provider, the settlement contract will automatically cancel. The provider will pay the owner of your policy or beneficiaries designated by the owner in the life settlement contract any proceeds it receives from your policy, minus any money it already paid for the purchase of your policy and any premiums it paid to the insurance company to keep your policy current. The insurance company or the provider should refund any unearned premiums paid.

What happens after I get my money?

After the provider has paid the owner for the sale of the policy, they may begin calling to check on the health status of the life settlor.

What if I don't want to be contacted about my health status?

If you do not want to be contacted about your health status, you may appoint an adult person or persons to be contacted on your behalf. That person must be in regular contact with you and you must give the provider their name, address and phone number. Once you give the provider this information, they may not contact you unless they have tried and have not been able to reach your contact person for more than 30 days. If you need to, you can change your contact person at any time by sending a written notice to the provider.

How will I know who will be calling me or my contact person about my health status and how often can they call?

The provider must give you the name, address, and phone number of the person who will be contacting you or your contact person(s) about your health status. If your life is expected to end in one year or less, contacts to check on your health status are limited to once every 30 days. If you are expected to live for more than one year, contact is limited to once every three months.

Will the provider be calling my doctor to check on my health status?

Some providers will use your signed medical release form to check with your doctor for updates on your health status. The medical release form tells your doctor that you want your doctor to give your medical information to the provider, their broker, or provider representative. If you decide you do not want the provider to contact your doctor, you have the right to withdraw your medical consent in accordance with law.

How will I know if my policy includes extra coverages like accidental death, future increases in the death benefit, or covers other family members? Do these affect my settlement?

Some policies contain extra coverages. You may want to contact your insurance company or agent to see if your policy contains a provision or rider providing extra coverages.

If your policy includes a benefit for accidental death, the additional death benefit may not be included as part of your settlement. The additional death benefit will remain payable to your beneficiaries or your estate.

If your policy provides future increases in the death benefit, you may want to ask how much the provider is paying you for the purchase of this benefit.

If your policy is a joint policy, or provides coverage on the lives of other family members or anyone other than yourself, there may be a possible loss of coverage.

Are there other options available besides selling my policy?

Your insurance company may offer options, such as accelerated death benefits, loans, and surrender of the policy for its cash value. Before entering into a life settlement, you should contact your insurance company or agent to see what options are available.

What other things should I know about a life settlement contract?

Some things that may be affected if you enter a life settlement are:

- there may be a loss of life insurance coverage on your spouse or other family members, if the policy (or any riders attached to it) covers their lives;
- the amount of premiums you pay;
- policy cash values or dividends, if provided for in the policy;
- a loss of other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the your policy;
- you may incur tax consequences;
- your ability to receive supplemental social security income, public assistance, and public medical services including Medicaid; and
- the money you receive for your life settlement could be taken away from you by creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.

Because of the above, you should contact an attorney, accountant, estate planner, financial planning advisor, tax advisor, social services agency, your insurance company, or agent, as applicable, to find out what effect selling your policy will have on you.

What is the time line from start to finish in respect to completing the sale of a policy?

<u>Stage</u>	<u>Timeline</u>
Application	1 day
Medical Records	2 to 4 weeks
Medical review	2 to 4 weeks
Illustrations	2 to 4 weeks
Offers	2 to 4 weeks
Contracts	2 weeks
Change of Ownership	2 to 3 weeks
Funding	2 to 5 days

The above timeline is only for indicative purposes, and therefore every effort will be made to complete each stage within the minimum time limits stipulated above.

ACKNOWLEDGMENT BY AGENT OR AGENT'S REPRESENTATIVE

I, _____, _____ of
Agent/Representative Name Title/Position
_____ (the "Agent") acknowledge that
Business Name

I have received the following documents from Wealth Increase Network, L.P.: (1) Life Settlement Application, (2) Broker of Record Form, (3) Authorization for Release of Medical and/or Insurance Information, (4) Physician's Letter of Competency for the First and Second Insured, and (5) Required Notice – Important information you need to know before entering a Life Settlement (the "Forms") with respect to a certain life insurance policy or policies, as further described below (collectively, the "Policy"). Agent further acknowledges that he or she has delivered the Forms to the owner of, and insured under, the Policy and that the Agent has used his or her best efforts to ensure that the owner and insured have signed those Forms where a signature is required. Agent further represents that he or she has reviewed the signatures of the owner and insured on those Forms where a signature is required and that, to the best of the Agent's knowledge, the signatures are substantially similar to the signatures of the owner and insured under the Policy submitted. Finally, Agent represents that (i) he or she has not paid, lent or advanced to the owner of the Policy or the insurance company that issued the Policy any funds for the purpose of paying premium payments on the Policy, other than any state-authorized payments or rebates of all or any portion of Policy commissions which you elected to pay to the owner of the Policy and (ii) he or she has no ownership rights or interests in the Policy, regardless of whether such rights or interests are recorded with the insurance company that issued the Policy or are obtained directly through a separate agreement or arrangement with the owner of the Policy.

Insured Name(s): _____
First Insured Second Insured

Policy Number: _____

Insurance Company: _____

X _____, as of the _____ day of _____, 200____
Agent/Representative Signature

Agent/Representative Name

AGENT: Name: _____

Company: _____

Tel: (_____) _____ **Fax:** (_____) _____ **email:** _____

Remarks _____
