2101 Park Center Drive, Suite 220
Orlando, FL 32835
800-561-4148 ♦ Fax: 407-296-7377
www.advancedsettlements.com

Policy Evaluation and Application Form

Personal Data

First Insured Name: ________________________________ SS #: ___________________________

Current Address: ____

City: ______________________ State: ______ Zip: ____________ Date of Birth: _______________

Second Insured Name: ______________________________ SS #: ___________________________

Current Address: ____

City:______________________ State: ______ Zip: ____________ Date of Birth: _______________

Telephone Numbers: Day: ________________________ Evening: _____________________________

Marital Status: ____________ Male: ____Female: ____ Dependent Children: _____Yes _____ No

Have you been or are you now a party to bankruptcy? _____ Yes _____ No
If yes, please attach all discharge papers.

Medical History

Please give a brief description of your medical condition:

____

____

Name of Personal Physician: ____

Address: ____

City/State/Zip: ____

Telephone: ____________________

Please list the names and phone numbers of any additional Physicians and/or Specialist

Name	Phone
____	_______________________
____	_______________________
____	_______________________

If policy owner is different than above

Policy Owner (*if other than insured*): ____

Name of Trustee: ______________________________ SS or Tax ID#: _________________________

Current Address: ____

City: ___________________________ State: _______ Zip: ________________________________

Telephone Numbers: Day: ______________________ Evening: _____________________________

Marital Status: ___________ Male: ____Female: ____ Dependent Children: _____Yes _____ No

Have you been or are you now a party to bankruptcy? _____ Yes _____ No
If yes, please attach all discharge papers.

*****Please list any additional owners or Trustees on a separate sheet.**

Life Insurance Policy Information

Name of Insurance Company: ____

Policy Number: ___________________________ Date of Issue: ______________________

Coverage/Face Amount: $______________________ Amount of Premium: _______________

Date the Last Premium was Paid:________________Date Next Premium is Due:_____________

Type of Policy: _____ Term _____ Whole Life _____ Universal Life _____ Other

Loans: $ ____________________ Current Surrender Value: $ _________________

Has this Policy ever lapsed? ____ Yes ____ No

What is the Reason for the Sale of this Policy?____

Fraud Notice

"Any person who knowingly presents false information in an application for insurance or an application for a life settlement / viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison."

Disclosure Notice and Advice to Policy Owner and Insured

1. 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. You should consult a professional tax advisor.

2. The sale of your insurance policy 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.

3. Advanced Settlements, Inc will only process your life insurance policy through licensed Providers/Purchasing Companies to the extent required by applicable law.

4. Advanced Settlements, Inc. will be compensated. The viatical settlement provider company, not the viator, will compensate Advanced Settlements, Inc. based on a formula that is a percentage of the face value of the life insurance policy. For example: compensation for a $100,000 policy could be: 6% x $100,000 (face value) = $6,000.00. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.

5. There may be possible alternative to 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.

6. The name, business address, and phone number of the entity that serves as independent third-party escrow agent that disburses your settlement proceeds is: [Furnished at your request]. You may, if you wish, inspect or receive a copy of the escrow agreement or documents for your settlement from the escrow agent.

7. Once you have received your proceeds from the sale of your life insurance policy, you may have fifteen (15) days from receipt of the viatical settlement proceeds in which to rescind the transaction. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds. Funds will be sent to you within (3) business days after the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

8. Advanced Settlements, Inc. and its Principals are affiliated with a Provider/Purchasing Company which could potentially acquire your insurance policy if it provides the best offer. Additional information with respect to the Provider/Purchasing Company will be provided to you prior to purchase in the event that such entity is the acquiror of your policy.

9. Settlement proceeds could be subject to the claims of creditors.

Applicant's Acknowledgement of Receipt of a Brochure on Viatical/Life Settlements.

By my signature hereinafter affixed, I/we confirm and acknowledge that I/we acknowledge receipt of a brochure describing the process of viatical/life settlements.

Signatures

I/We understand that Advanced Settlements, Inc. has a duty to find the best offer available for my/our life insurance policy (ies). Therefore, I /we hereby grant to Advanced Settlements, Inc. the exclusive right to broker my/our life insurance policy (ies) which may only be terminated upon sixty (60) days prior written notice.

I/We agree that this application will become part of my/our viatical/life settlement contract if my/our life insurance policy is purchased. I/We agree that all of the information provided in this application is material and represent and warrant that all of the information is true and correct to the best of my/our knowledge. I/We acknowledge that I/We have read and understand the contents of the DISCLOSURE NOTICE.

______________________________	______________________________
Signature of Insured 1	Signature -Policy Owner-*if other than insured*
______________________ ________	______________________ ________
Printed Name of Insured 1 Date	Printed Name of Policy Owner Date
______________________________	______________________________
Signature of Insured 2	Signature of Broker or Provider
______________________ ________	______________________________
Printed Name of Insured 2 Date	Printed Name of Broker or Provider
______________________________	
Signature of Witness	
______________________ ________	
Printed Name of Witness Date	

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AUTHORIZATION FOR DISCLOSURE OF POLICY INFORMATION AND PROTECTED HEALTH INFORMATION
(HIPAA Compliant)

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, or any other institution or person (each, an "Authorized Discloser") to provide **Advanced Settlements, Inc.** and/or its authorized representatives, my life insurer (collectively, the "Authorized Recipient") 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. This authorization shall apply to any and all of the insured's health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

3. Release of Policy Information. I understand that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my life insurance company to furnish Advanced Settlements, Inc. with any information herein described above.

4. I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy of this facsimile of this authorization shall be valid as the original.

5. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, 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.

6. Right to Revoke Authorization: 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.

7. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: I understand that 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, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized Discloser 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. 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 an application for insurance or an application for a life settlement / viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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Authorized Disclosers

Signature of Insured 1	Signature-Policy Owner/Viator – *if other than insured*
Printed Name of Insured 1 Date	Printed Name of Policy Owner Date
Signature of Insured 2	Signature of Witness
Printed Name of Insured 2 Date	Printed Name of Witness Date
Signature of Witness	
Printed Name of Witness Date	