INSURANCE RESOURCES GROUP

LIFE SETTLEMENT APPLICATION

The information herein will be held in the strictest confidence.

INSURED'S INFORMATION

Insured's Name: ____
Social Security #: __________ - __________ - __________
Street Address: (*No PO Box*) ____
City: _______________________________________ State: __________ Zip Code: ______________
Home Phone: _________________________ Work Phone: ____________________________
Fax #: _______________________________ E-mail Address: __________________________
Date of Birth: ________ /________ /________ Sex: Female ☐ Male ☐
Spouse's Full Name: _________________________ Spouse's Date of Birth: _______ /_______ /______

EMPLOYMENT STATUS

Are you currently retired? Yes ☐ No ☐ Do you work? Yes ☐ No ☐
Current employer and occupation: ____

LIFE INSURANCE POLICY INFORMATION ***(please provide for each policy being offered for sale)***

Name of Insurance Company:____
Policy Number: ______________________________ Face Value: $___________________________
Policy Issue Date _________________ Insuring – Individual ☐ Survivorship ☐
Policy Type - Universal ☐ VUL ☐ Term ☐ Whole Life ☐ Group ☐
If Term policy, can be converted until what date? ________________________
Annual Premium ____________ Paid A ☐ SA ☐ Q ☐ M ☐ Next premium due date_________
Owner of Policy: ____
Owner Address: ____
Phone: ______________________________ Fax: ___________________________________

Complete Trust or Corporation name, and names of Trustee(s) or 2 officers___________________________
____

Beneficiary (ies): ____
Primary Beneficiary Address: ____

Reason for original purchase: Estate Planning ☐ Family Protection ☐
Buy-sell agreement ☐ Other (describe):_________________________
Reason for selling: ____

Has an application for insurance on insured's life/health ever been declined, rated or modified in any way (including this policy)? Yes ☐ No ☐ If yes, give company and reason:
____

Does the insured have plans to purchase new life insurance? ____________________

Total face value of life insurance NOT being offered for sale herewith ______________________________

MEDICAL

Please list any specific health conditions ____

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:

(A) Frequency of use? Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐

(B) Amount consumed on each occasion: ____

(C) Any treatment for alcohol use (including AA treatment)? ________________________________

FAMILY HISTORY		Current Age	Deceased?	If deceased, cause and age at time of death
(A)	Father	_______	Yes ☐ No ☐	______________________________
(B)	Mother	_______	Yes ☐ No ☐	______________________________
(C)	(Brother) (Sister)	_______	Yes ☐ No ☐	______________________________
(D)	(Brother) (Sister)	_______	Yes ☐ No ☐	______________________________

Please list insured's Primary Care Physicians:

Name: ______________________________ Name: ______________________________

Address: ______________________________ Address: ______________________________

City, State, Zip: ______________________________ City, State, Zip: ______________________________

Phone #: ______________________________ Phone #: ______________________________

Please list any Specialist that insured has seen:

Name: ______________________________ Name: ______________________________

Address: ______________________________ Address: ______________________________

City, State, Zip: ______________________________ City, State, Zip: ______________________________

Phone #: ______________________________ Phone #: ______________________________

Attach additional pages if needed. Give a copy of the letter enclosed to the above physicians/specialists (make copies as needed.)

FINANCIAL

Has insured applied for or received a pension or compensation because of illness or injury? Yes ☐ No ☐

If yes, give details of illness or injury: ____

____

Has owner been a party to a: [check all that apply] Civil Suit ☐ Bankruptcy ☐ Judgments ☐ Creditor Liens ☐ Tax Liens ☐

Explain any checked answers on a separate page and attach all discharge papers.

Does insured have a living will? Yes ☐ No ☐

PERSONAL ACKNOWLEDGEMENT

I represent and warrant that the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify Insurance Resources Group of any changes in the information. I further give my consent to Insurance Resources Group and its agents to release this application and all information gathered while processing it as necessary for the sole purpose of soliciting the purchase of my life insurance policy. I acknowledge that I am submitting this application for Insurance Resources Group to evaluate the purchase of my life insurance policy and that Insurance Resources Group is under no obligation to purchase my policy. I acknowledge I may be contacted by Insurance Resources Group regarding the information contained in this application.

I understand that some or all of the proceeds from a life settlement may be taxable and that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that neither Insurance Resources Group nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

Owner's signature: ____

Typed or printed name: ______________________________ Date: ________________

Witness signature:______________________ Printed Name ________________Date: __________

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. Insurance Resources Group strongly urges you to consult your own attorney or tax advisor concerning this transaction. Insurance Resources Group 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 rights 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 Insurance Resources Group 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 Insurance Resources Group. 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 Insurance Resources Group 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 Insurance Resources Group has received the insurer's 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 contract shall be deemed rescinded.

Insured's Name: ______________________________ Social Security: ________ - ________ - ________

NOTICE OF DISCLOSURE (continued)

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.

I acknowledge that I have read and understand the contents of this disclosure and have read and understand the attached “How a Life Settlement Operates”.

Owner’s Signature: ____ Date: __________________

Typed or Printed Name: ____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically-related facility, insurance support organization, pharmacy, or any other institution or person to provide Insurance Resources Group or its designee, 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, of or relating to the patient named below.

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 information in your possession 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 your possession and control. I agree that this authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

______________________________	______________________________
Signature of Insured	Printed Name of Insured
______________________________	______________________________
Date Signed	Social Security Number
______________________________	______________________________
Signature of Witness	Printed Name of Witness
______________________________	
Date Signed	

9744 Wilshire Blv#306 Beverly Hills,CA 90212 (310)550-3300 Fax(310)550-3390

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RELEASE OF POLICY INFORMATION

I hereby authorize ____, the issuer of Policy Number ________________________ and/or Certificate Number _______________________ owned by ______________________________ and insuring the life of ____________________________, to release to Insurance Resources Group or its authorized agents, a copy of the policy, forms, riders or amendments of this policy. I respectfully request that you reply immediately to any request for information or letters required by Insurance Resources Group or its agents pertaining to this policy or employment information. I agree that this authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

___________________________________ Signature of Owner

________________________________ Printed Name of Owner

____________________________________ Date Signed

________________________________ Social Security Number

____________________________________ Signature of Witness

________________________________ Printed Name of Witness

___________________________________ Date Signed

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LETTER TO PHYSICIAN

Date: ___________________________

Doctor Name: ____

Doctor Address: ____

____

RE: Patient Name: ____

Social Security/Medical ID#: ____

Dear Sir or Madam:

I am currently working with Insurance Resources Group in order to sell my life insurance policy. Insurance Resources Group or its designated agents will be contacting you in the near future in order to obtain my medical information.

Please respond promptly to any requests received and provide them with all information requested in order to expedite the processing of my life settlement.

This letter will serve as acknowledgement that I consent to the release of my records and request that this letter be put in my file for future reference, should future release of information be needed by Insurance resources Group.

Thank you for your time and cooperation.

Sincerely,

____
Insured's Name

____
Printed Name of Insured

AGENT 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 agent of record for the sale of the above mentioned policy is __________________________.

____ Date __________________________
Signature of Owner

____
Address

____ Date __________________________
Witness

____
Printed name of witness

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CHECKLIST FOR APPLICATION PACKAGE

This checklist was designed to help you ascertain if you have completed all pertinent items in order to expedite processing of the life settlement.

The following items must be received by Insurance Resources Group in order for the policy to be processed:

- ❑ Application must be filled out completely, signed and witnessed. Anything that is not applicable, mark "N/A".
- ❑ The release forms for Medical and Policy Information must be signed, witnessed and dated by appropriate parties as indicated.
- ❑ The Notice of Disclosure must be signed, dated and notarized.
- ❑ 2 years of medical records for attending physicians, current within 30 days of application.
- ❑ Agent of Record Letter signed, dated and witnessed.
- ❑ 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. If this is not available immediately, please make a note for us on the application and forward as soon as possible.
- ❑ Current in-force illustration from the insurance company with application showing the following:
  - ❑ Universal Life – minimum premium payment to maturity.
  - ❑ Term – proposed conversion illustration to Universal showing a minimum payment to maturity.
  - ❑ Whole Life – run a natural vanish premium illustration to maturity.
- ❑ Owner and Beneficiary (ies) of the policy.

  If owner/beneficiary is a trust, we need:
  - ❑ Copy of trust and Tax ID #
  - ❑ Trustee (s) must sign the policy information release form

  If owner/beneficiary is a corporation, we need:
  - ❑ Complete name and address of corporation.
  - ❑ Corporate resolution showing current authorized officers.
  - ❑ Two officers must sign the policy information release form

In addition, please send the "Letter to Physician" directly to the physicians/specialists listed on the application.

FOR AGENTS ONLY: Broker ______________________________

Representing Agent ____
Address____
Phone __________________________ Fax ____________________
Is the representing agent the agent of record on the policy? ___________________

____ ____________________
Agent Signature Date