



## Settlement Funding LLC

Dear Customer:

I've enclosed a **Data Collection Form for you to complete and sign**. I'll need to get a **copy of your policy** and an **in force illustration of cost thru age 100 with \$1 left in cash value** (assume 4% market return over time). I'll request the illustration from your insurance company and medical records for the insured as soon as this application is returned. Please return this information by email: [Ray@AtAge60.com](mailto:Ray@AtAge60.com), fax (703) 319-0922 or mail to address below.

Sincerely,

Ray A. Towles  
Life Settlement Agent



# Settlement Funding LLC

## DATA COLLECTION FORM FOR LIFE INSURANCE SETTLEMENT

### POLICY OWNER

NAME OF POLICY OWNER(S)

NAME OF SIGNING OFFICER (IF CORPORATE OWNED) OFFICER TITLE

NAME OF TRUSTEE(S) (IF TRUST OWNED) DATE OF TRUST TIN OR SSN

ADDRESS EMAIL TELEPHONE NUMBER

CITY STATE ZIP

If individually owned, has policy owner ever been? (Check all that apply)

- Married
- Divorced
- Legally Separated
- Widowed
- Bankrupt

If more than one policy is being submitted, please attach an additional page including policy owner(s) and life insurance policy information as requested above.

### LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY POLICY NUMBER ISSUE DATE

FACE AMOUNT TOTAL POLICY LOAN CASH SURRENDER VALUE

ANNUAL PREMIUM PAYMENT NEXT PREMIUM DUE

LAST PREMIUM PAID DATE AMOUNT PAID CUSTOMER SERVICE PHONE NUMBER

PREMIUM MODE:

- Annual
- Semi-Annual
- Quarterly
- Monthly

TYPE OF POLICY:

- Term
- UL
- SUL
- WL
- SWL
- VUL
- SVUL
- Other
- Individual
- Group
- Converted Group

REASON FOR SALE

Settlement Funding LLC  
 1714 Tyvale Court Vienna, VA 22182  
 Telephone: (703) 928-6000 Fax: (703) 319-0922

**PERSONAL INFORMATION-FIRST INSURED**

INSURED NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

CURRENT HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

MARITAL STATUS:

Married  Divorced  Legally Separated  Widowed

INSURED'S DRIVERS LICENSE NUMBER & STATE \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

**PERSONAL INFORMATION- SECOND INSURED**

INSURED NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

CURRENT HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

TELEPHONE NUMBER \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_

MARITAL STATUS:

Married  Divorced  Legally Separated  Widowed

INSURED'S DRIVERS LICENSE NUMBER & STATE \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

**BENEFICIARY INFORMATION - ATTACH ADDITIONAL PAGE IF NECESSARY**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER OR TIN \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

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**MEDICAL INFORMATION - FIRST INSURED**

Please provide a brief description of your medical condition and the reason you are considering a Life Settlement:

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**MEDICAL INFORMATION - SECOND INSURED**

Please provide a brief description of your medical condition and the reason you are considering a Life Settlement:

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***First Insured***

NAME OF PRIMARY PHYSICIAN \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF SPECIALIST PHYSICIAN \_\_\_\_\_ SPECIALTY \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

***Second Insured***

NAME OF PRIMARY PHYSICIAN \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

NAME OF SPECIALIST PHYSICIAN \_\_\_\_\_ SPECIALTY \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

If there are any other physicians who have treated you in the last five years, please attach an additional page including full name of physician(s), specialty, address and telephone number with area code.

**ADDITIONAL PHYSICIAN PAGE**

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NAME OF SPECIALIST PHYSICIAN	SPECIALTY	TELEPHONE WITH AREA CODE
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ADDRESS

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CITY	STATE	ZIP
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NAME OF SPECIALIST PHYSICIAN	SPECIALTY	TELEPHONE WITH AREA CODE
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ADDRESS

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CITY	STATE	ZIP
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NAME OF SPECIALIST PHYSICIAN	SPECIALTY	TELEPHONE WITH AREA CODE
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ADDRESS

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CITY	STATE	ZIP
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NAME OF SPECIALIST PHYSICIAN	SPECIALTY	TELEPHONE WITH AREA CODE
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ADDRESS

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CITY	STATE	ZIP
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## PERSONAL ACKNOWLEDGEMENT

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

I understand that some or all of the proceeds from a Life Insurance 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 Settlement Funding LLC, nor any of its representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

I acknowledge that any person who knowingly presents false information in a Data Collection Form or application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

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PRINT NAME OF POLICY OWNER(S)

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SIGNATURE OF OWNER(S)

DATE

Settlement Funding LLC  
1714 Tyvale Court Vienna, VA 22182  
Telephone: (703) 928-6000 Fax: (703) 319-0922

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

Patient's (Insured) Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_

I, the undersigned, hereby authorize the disclosure of my protected health information as follows:

1. **Classes of Persons Authorized to Disclose My Protected Health Information:** I authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider or other institution or person(s) having any medical records, charts, X-rays, laboratory work or similar information regarding my health ("Authorized Discloser"), to release and disclose such information ("Protected Health Information") as provided in this authorization. I authorize each Authorized Discloser to rely upon a photographic or facsimile copy or other reproduction of this document.
2. **Persons Authorized to Receive My Protected Health Information** I authorize my Protected Health Information to be released and disclosed by each Authorized Discloser under this authorization **Settlement Funding LLC** any of its principals, employees, agents or other authorized representatives and/or their successors, assigns, designees and affiliated entities (collectively, the "Authorized Recipient").
3. **Description of Protected Health Information Authorized for Disclosure and the Purpose for such Disclosure:** authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to, the following:
  - Physician's/nurse's notes;
  - Examination summaries;
  - Reports and Orders;
  - Medication and Prescription Drug records;
  - Radiology, pathology and other laboratory or test reports; and
  - Other information/documentation included in a medical file.

This information and all disclosures of my Protected Health Information made pursuant to this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health and medical status and condition in connection with any and all life insurance policies under which any life is insured that are sold.

4. **Expiration of Authorization:** This Authorization shall remain valid until and shall expire on, the date of my death.
5. **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 or my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated 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 notice of my revocation or if this authorization was obtained.

I acknowledge and 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 "HIPPA Privacy Regulations"). I further understand that, as a result of this authorization, my Protected Health Information disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and that my Protected Health Information that is disclosed to the Authorized Recipient may no longer be protected by the HIPPA Privacy Regulations.

I certify that I am executing and delivering this authorization freely, voluntarily and unilaterally as of the date written below. I further certify that I understand this authorization written in plain language and that I have retained a copy of this signed authorization for future reference.

\_\_\_\_\_  
Signature of Patient (Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient (Insured)

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**AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION**  
**(Signed by the Policy Owner/Applicant)**

I hereby authorize my insurance company to release directly to Settlement Funding LLC and/or its authorized representatives with any information and forms in connection with my policy (including, but not limited to, verification of coverage, any illustrations or any conversions, thereof). As per my specific instructions, as the Policy Owner, please fax the requested information to Settlement Funding LLC directly and forward a copy to me.

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 three years, absent any of provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted, there under.

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PRINT NAME OF POLICY OWNER(S)

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ADDRESS

SOCIAL SECURITY NUMBER OR TAX ID NUMBER

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CITY

STATE

ZIP

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SIGNATURE OF POLICY OWNER

DATE

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## Settlement Funding LLC

This Data Collection Form is for:  a viatical settlement  a life settlement  
(Please check only one.)

**Life Settlements** enable people who no longer want or need their life insurance – and *who do not have a catastrophic or life-threatening illness or condition* – to receive an advance cash payment for their policy. Life expectance is usually more than 24 months.

**Viatical Settlements** provide that same option to people who do have a catastrophic or life-threatening illness or condition. Life expectance is usually less than 24 months.

## DISCLOSURE NOTICE: A NOTICE TO APPLICANTS

**We at Settlement Funding LLC, a life settlement company, do hereby advise you that:**

1. There are possible alternatives to a life settlement contract including, but not limited to, accelerated death 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 recommend that you obtain information from your insurance company or your advisors regarding the options available to you.
2. Some or all of the proceeds of your settlement may be taxable under federal income tax and/or state franchise and income tax laws. Assistance should be sought from a professional tax advisor. We make no representation and give 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 and public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. The proceeds of a life settlement could be subject to the 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 or premium benefits that may exist under the policy forfeited by you.
7. All medical, financial, or personal information solicited or obtained by Settlement Funding LLC 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 Settlement Funding LLC. 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.

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8. One consequence of selling your insurance policy will be the loss of the death benefit payable to the current beneficiary(ies).
9. Settlement Funding LLC will be compensated. The settlement provider company, *not the insured*, will compensate Settlement Funding LLC 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:  $6\% \times \$100,000$  (face value) = \$6,000. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.
10. You have the right to rescind your settlement before the earlier of thirty (30) calendar days after the date upon which the settlement contract is executed by all parties or fifteen (15) calendar days after the receipt of the settlement proceeds. If exercised, rescission is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans and loan interest to the settlement provider is made within the rescission period. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds and any premiums, loans and loan interest to the settlement provider. Funds will be sent to you within three (3) business days after the settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the settlement contract.
11. The insured may be contacted by the settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact shall 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.

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PRINT NAME OF POLICY OWNER(S)

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ADDRESS SOCIAL SECURITY NUMBER OR TAX ID NUMBER

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CITY STATE ZIP

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X  
SIGNATURE OF POLICY OWNER(S) DATE

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