



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, fax (703) 319-0922 or mail to address below.

Sincerely,

Ray A. Towles
Life Settlement Agent



Settlement Funding LLC

DATA COLLECTION FORM FOR VIATICAL SETTLEMENT

POLICY OWNER/VIATOR

NAME OF POLICY OWNER(S)/VIATOR(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)/viator(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 Viatical Settlement:

MEDICAL INFORMATION - SECOND INSURED

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

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

NAME OF SPECIALIST PHYSICIAN	SPECIALTY	TELEPHONE WITH AREA CODE
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ADDRESS

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

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

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

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 Data Collection Form.

I understand that some or all of the proceeds from a Viatical 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 on a Data Collection Form for insurance or/a Viatical settlement is guilty of a crime and may be subject to fines and confinement in prison.

PRINT NAME OF POLICY OWNER(S)/VIATOR(S)

SIGNATURE OF OWNER(S)/VIATOR(S)

DATE

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**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 Disclosure"), to release and disclose such information ("Protected Health Information") as provided in this authorization. I authorize each Authorized Disclosure 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 Disclosure 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/Viator)

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

PRINT NAME OF POLICY OWNER(S)

ADDRESS

SOCIAL SECURITY NUMBER OR TAX ID NUMBER

CITY

STATE

ZIP

SIGNATURE OF POLICY OWNER

DATE

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DISCLOSURE NOTICE: A NOTICE TO APPLICANT

(A)(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall disclose at least the following to a viator no later than the time all parties sign the application for the viatical settlement contract:

(a) That there are possible alternatives to viatical settlement contracts, including any accelerated death benefits offered under the viator's life insurance policy or certificate;

(b) That some or all of the proceeds of the viatical settlement may be subject to federal income taxation and state franchise and income taxation, and that assistance should be sought from a professional tax advisor;

(c) That the proceeds of the viatical settlement could be subject to the claims of creditors;

(d) That receipt of the proceeds of the viatical settlement may adversely affect the viator's eligibility for medical assistance under Chapter 5111. of the Revised Code or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies;

(e) That the viator has a right to rescind the viatical settlement contract for at least fifteen calendar days after the viator receives the viatical settlement proceeds, as provided in section 3916.08 of the Revised Code. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds to the viatical settlement company.

(f) That funds will be sent to the viator within three business days after the viatical settlement provider has received acknowledgment from the insurer or group administrator that ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated pursuant to the viatical settlement contract;

(g) That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial advisor.

(2) The viatical settlement provider or viatical settlement broker shall provide the disclosures under division (a)(1) of this section in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker.

(3) Disclosure to a viator under division (a)(1) of this section shall include distribution of a brochure describing the process of viatical settlements. The viatical settlement provider or viatical settlement broker shall use the NAIC's form for the brochure unless one is developed by the superintendent.

(4) The disclosure document under division (a)(1) of this section shall contain the following language:

"All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(B)(1) A viatical settlement provider shall disclose at least the following to a viator prior to the date the viatical settlement contract is signed by all the necessary parties:

(a) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy or certificate to be viaticated;

(b) The name, address, and telephone number of the viatical settlement provider;

(c) Regarding a viatical settlement broker, the amount and method of calculating the broker's compensation. As used in this division, "compensation" includes anything of value paid or given to a viatical settlement broker for the placement of a policy or certificate.

(d) If an insurance policy or certificate to be viaticated has been issued as a joint policy or certificate or involves family riders or any coverage of a life other than the insured under the policy or certificate to be viaticated, the possible loss of coverage on the other lives under the policy or certificate and that advice should be sought from the viator's insurance producer or the company issuing the policy or certificate;

(e) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate, and, if known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the viatical settlement provider's interest in those benefits.

(f) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

If the provider transfers ownership or changes the beneficiary of the insurance policy or certificate, the provider shall communicate the change in ownership or beneficiary to the insured within twenty days after the change.

Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator.

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

PRINT NAME OF POLICY OWNER(S)/VIATOR(S)

ADDRESS SOCIAL SECURITY NUMBER OR TAX ID NUMBER

CITY STATE ZIP

X

SIGNATURE OF POLICY OWNER(S)/VIATOR(S) DATE

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