

Creative *Life* Solutions

Life Settlement Application

General Info

Name of Insured _____

Street address _____

City / State / Zip _____

Telephone Home () _____ - _____ Cell () _____ - _____

Please include a photocopy of your State issued I.D and your Social Security card

Marital Status _____ Children under 18 Y / N

Have you ever filed for Bankruptcy Y / N Do you now have a tax lien Y / N

Are you currently receiving: Medicaid, food stamps or any income from the Social Security Administration? Y / N

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Name of Policy Owner (if different from insured) _____

Street Address _____

City / State / Zip _____

Best Telephone Number () _____ - _____ Home / Work / Cell

Policy Info

Name of Insurance Carrier _____

Policy Number _____ Issue Date ____/____/____ Face Amount \$ _____

Policy Type: Universal Term Survivorship Whole life

Is this policy a group or term conversion? Y / N Date of Conversion ____/____/____

If this is group coverage, please provide the group organization contact information:

Name of Organization _____

Telephone Number () _____ - _____

Please send a complete copy of your policy along with this Life Settlement application

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Medical History of Insured

Do you have any history of:

High Blood Pressure	Y / N	Diabetes	Y / N
Heart Disease	Y / N	Cancer	Y / N
Kidney Disease	Y / N	High Cholesterol	Y / N
Liver Disease	Y / N	Tobacco use	Y / N

Please describe your current medical condition

Primary Care Physician:

Name _____
Street address _____
City/State/Zip _____
Telephone () _____ - _____
Fax () _____ - _____

Date of last Visit ____/____/____

Please list all other physicians on the Physicians Contact Page provided

Applicant Representative Info

I have been introduced to Creative Life Solutions as the result of a referral from _____ . Please keep this person up to date on the status of the possible sale of my policy.

The applicant represents that all information in this application are true and correct to the best of his/her knowledge. The statements contained in this application are considered to be representations and not warranties. The applicant acknowledges receipt of Notice of disclosure. Any person who knowingly and with the intent to defraud another presents or causes to be presented any statement forming a part of or in support of an application for insurance or viatical settlement contract any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, commits a fraudulent viatical settlement act and is subject to civil and criminal penalties.

Signature of Applicant

Date

Print Name

Creative *Life* Solutions

Supplementary Application

Second Insured

Name of Insured _____

Please include a photocopy of your State issued I.D and your Social Security card

Marital Status _____ Children under 18 Y / N
Have you ever filed for Bankruptcy Y / N Do you now have a tax lien Y / N
Are you currently receiving: Medicaid, food stamps or any income from the Social Security Administration? Y / N
Social Security Number ____-____-____ Date of Birth ____/____/____

Medical History of Second Insured

Do you have any history of:

High Blood Pressure	Y / N	Diabetes	Y / N
Heart Disease	Y / N	Cancer	Y / N
Kidney Disease	Y / N	High Cholesterol	Y / N
Liver Disease	Y / N	Tobacco use	Y / N

Please describe your current medical condition

Primary Care Physician:

Name _____

Street address _____

City/State/Zip _____

Telephone () _____ - _____

Fax () _____ - _____

Date of last Visit ____/____/____

Please list all other physicians on the Physicians Contact Page provided

The applicant represents that all information in this application are true and correct to the best of his/her knowledge. The statements contained in this application are considered to be representations and not warranties. The applicant acknowledges receipt of Notice of disclosure.

Signature of Applicant

Date

Print Name

Creative *Life* Solutions

Additional Physicians

Physician:

Name _____

Specialty _____

Street address _____

City/State/Zip _____

Telephone () _____ - _____

Fax () _____ - _____

Date of last Visit ____/____/____

Physician:

Name _____

Specialty _____

Street address _____

City/State/Zip _____

Telephone () _____ - _____

Fax () _____ - _____

Date of last Visit ____/____/____

Physician:

Name _____

Specialty _____

Street address _____

City/State/Zip _____

Telephone () _____ - _____

Fax () _____ - _____

Date of last Visit ____/____/____

Release of Information Authorization

Patient Name _____
Social Security # _____
Date of Birth _____

Release of Medical Information (HIPAA)

I hereby authorize any physician, medical facility, hospital or healthcare provider as well as any other person or entity in possession of my protected health information to release to Creative Life Solutions and / or its authorized representatives **any and all medical records** including but not limited to doctors notes, labs and diagnostic tests as well as any information regarding HIV, AIDS, ARC, confidential drug and / or alcohol abuse treatment, mental health treatments, insurance, referral documents, records from other facilities and any other medical record information that may be requested that is not already listed above

This authorization is valid for Twenty-Four (24) months from the date of signing and a facsimile or photocopy is as valid as the original. I understand that I may request a copy of this authorization and that this authorization may be withdrawn by written request at any time. I understand that this protected health information, once disclosed, may be re-disclosed to individuals or organizations not subject to HIPAA and, therefore, may no longer be protected by HIPAA.

Signature of Patient

Signature of Witness

Printed Name

Printed Name

Date



Release of Information Authorization

Name of Insurance Company _____
 Name of Insured _____
 Name of Policy Owner (if different from insured) _____
 Policy Number / s _____
 Social Security Number _____
 Date of Birth _____

Release of Policy Information

I hereby authorize the insurance company listed above to release to Creative Life Solutions any and all information relating to my policy listed on this form. This is inclusive of, but not limited to policy values, verification of coverage, premium illustrations, information contained on the application I completed to obtain this policy, beneficiary, reinstatement, forms, riders and amendments as well as any other information that may be requested.

This authorization is valid for Twenty-Four (24) months from the date of signing and a facsimile or photocopy is as valid as the original. I understand that I may request a copy of this authorization and that this authorization may be withdrawn by written request at any time.

Signature of Insured / Owner

Signature of Witness

Printed Name

Printed Name

Date

Creative *Life* Solutions

Broker of Record

Name of Policy
Owner

Name of Insured

Policy number

Insurance Company

Dear Life Settlement Provider,

Please be advised that I have extended exclusive rights to Creative Life Solutions to pursue a settlement for my life insurance policy as listed above. This letter rescinds all previous appointments and shall remain in effect until written notice is provided otherwise.

Best Regards,

Policy Owner Signature

Date

Printed Name

Disclosure Statement (Client Copy)

- (1) There are possible alternatives to viatical settlement contracts for persons who have a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.
- (2) Proceeds of the viatical settlement may be taxable, and assistance should be sought from a personal tax advisor.
- (3) Viatical settlement proceeds could be subject to the claims of creditors.
- (4) Receipt of viatical settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate agencies.
- (5) All viatical settlement contracts entered into in this state must contain an unconditional rescission provision which allows the viator to rescind the contract within 15 days after the viator receives the viatical settlement proceeds, conditioned on the return of such proceeds. Funds will be sent to the viator within three business days after the provider of viatical settlements has the insurer's acknowledgement that ownership of the policy has been transferred and the beneficiary has been designated.
- (6) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator may inspect or receive copies of the relevant escrow or trust agreements or documents.
- (7) Creative Life Solutions, Inc. will be compensated. The life settlement provider company, not the viator, will compensate Creative Life Solutions, 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: $6\% \times \$100,000$ (face value) = \$6,000. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.
- (8) Creative Life Solutions, Inc. will evaluate the possible purchase of my life insurance policy. Creative Life Solutions, Inc. is under no obligation to broker the sale of my policy and makes no representation or guarantee that the policy will be sold. Creative Life Solutions, Inc. is not responsible for any failure on the part of a potential buyer to purchase the policy on terms offered by a potential buyer through Creative Life Solutions, Inc. Creative Life Solutions, Inc. is not responsible for the accuracy of any representations made by a potential buyer of the policy. The Applicant will look solely to the potential buyer of the policy in the event that the Applicant is of the belief that a potential buyer has made misrepresentations to the Applicant or otherwise failed to perform on purchase offers or other promises.
- (9) Entering into a viatical settlement 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. Assistance should be sought from a financial advisor.

No signature required – Please keep this copy for your records.