PROFESSIONAL LIFE
SETTLEMENTS PLUS
DON'T JUST SETTLE IN LIFE: CHOOSE LIFE SETTLEMENTS PLUS

LIFE INSURANCE SETTLEMENT APPLICATION CHECKLIST

Date:_____/_____/_____

Insured's Name:_____Age____Years.

The information you provide on this application packet will allow PLUS Financial Network (PFN) to evaluate your request to sell your life insurance policy. Please answer the questions completely and to the best of your knowledge and ability. All of the information provided to PFN on these documents will be held in the strictest confidence. Please return the application and materials to PFN using the return envelope provided.

PLEASE CHECK THE FOLLOWING

_____ Completed "Application" and Signed "Release of Information" forms.

_____ Copies of Other Documents Required From Page 2 of the Application.

_____ A Copy of your insurance policy(s).

_____ Copies of Medical Records from all physicians you have seen within the last 3 to 4 years. This includes office notes, labs, pathology reports, etc. (Our staff will obtain these if necessary)

PLEASE USE THIS FORM AS A GUIDE FOR SUBMITTING ALL NECESSARY FORMS. IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CONTACT US AT: 1-877-475-5244

APPLICATION FOR LIFE INSURANCE SETTLEMENT

INSURED'S PERSONAL INFORMATION

INSURED NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CURRENT HOME ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)	

☐ Single ☐ Married ☐ Widowed ☐ Divorced

PLEASE CHECK MARITAL STATUS ABOVE

INSURED'S DRIVERS LICENSE # & STATE	MALE / FEMALE	PLACE OF BIRTH

INSURED'S MEDICAL INFORMATION

NAME OF PRIMARY ATTENDING PHYSICIAN	DATE LAST SEEN	TELEPHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE

NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #1

NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #2

HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

ADDITIONAL MEDICAL HISTORY

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If you have any additional physicians or medical information to inform us about, please attach a separate sheet with complete details.

LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY | POLICY NUMBER | ISSUE DATE

☐ Individual ☐ Group ☐ Joint Survivorship ☐ Other

TYPE OF POLICY (PLEASE CHECK ONE)

IF POLICY IS A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP

☐ Term ☐ Whole Life ☐ UL ☐ Group ☐ Other

CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

FACE AMOUNT | TOTAL POLICY LOAN AMOUNT | CASH SURRENDER VALUE

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly $

POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX) | PREMIUM AMOUNT

PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ALL BENEFICIARIES OF THE POLICY (IF IT IS A TRUST, PROVIDE NAME AND ADDRESS OF TRUSTEE)

ADDITIONAL BENEFICIARIES

WHAT IS THE SPECIFIC PURPOSE FOR THE SALE OF THE POLICY OR POLICIES?

POLICY OWNER INFORMATION

NAME OF POLICY OWNER | SOCIAL SECURITY OR TAX ID NUMBER

NAME OF PRESIDENT / TRUSTEE (IF CORPORATE / TRUST OWNED POLICY) | DATE OF INCORPORATION / TRUST

HAS POLICY OWNER EVER DECLARED BANKRUPTCY? | IF SO, HAS IT BEEN DISCHARGED? | WHEN?

ADDRESS | TELEPHONE NUMBER

CITY | STATE | ZIP CODE

FINANCIAL PROFESSIONAL INFORMATION

NAME OF REFERRING FINANCIAL PROFESSIONAL | TELEPHONE NUMBER

IF A FINANCIAL PROFESSIONAL DID NOT REFER YOU, HOW DID YOU FIND OUT ABOUT OUR COMPANY?

IMPORTANT: ***Please include the following documents with your application, if applicable. This will allow us to process your application much more efficiently.***

1. **PHOTOCOPY OF ANNUAL POLICY STATEMENT**
2. **PHOTOCOPY OF INSURANCE POLICY OR POLICIES**
3. **PHOTOCOPY OF TRUST OR CORPORATE PAPERS**
4. **PHOTOCOPY OF DIVORCE DECREE** (Insured and Policy Owner)
5. **PHOTOCOPY OF BANKRUPTCY DISCHARGE** (Insured and Policy Owner)

If we do not receive this information, the processing of the application will be delayed.

PERSONAL ACKNOWLEDGEMENTS

I do 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 PLUS Financial Network (PFN) of any changes in the information. I furthergive my consent to PFN and its agents to release this application and all information gathered while processingincluding, but not limited to all medical records, notes, and lab reports, pertaining to my illness for the purpose ofsoliciting the sale of my life insurance policy. I acknowledge that I am submitting this application for you to evaluatethe purchase of my life insurance policy and that you are under no obligation to purchase my policy.

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

_____	_____	_____
Signature of Patient / Insured	Printed Name	Date
_____	_____	_____
Signature of Policy Owner (*if not Insured*)	Printed Name	Date

NOTICE OF DISCLOSURE

1. There may be alternatives to a viatical or senior settlement contract including, but not limited to, accelerated benefits 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 policy.

2. Some or all of the proceeds of your settlement may be taxable. PFN strongly urges you to consult your own attorney or tax advisor concerning this transaction. PFN 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 the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.

4. Along with this application and its disclosures, PFN has provided an additional informational/disclosure booklet for the Policy Owner. If you have not received this booklet, please call 1-877-475-5244 to have one delivered to you, otherwise you acknowledge receipt of this booklet.

This disclosure is being made to you in compliance with the State Insurance Codes, where applicable.

I, the applicant, do hereby acknowledge that I have read and understand the contents of this disclosure.

Please Sign Before A Witness

_____	_____	_____
Signature of Policy Owner	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date

Authorization for the Release of Information – HIPAA Compliant

I, _____DOB_____SS#_____ (*Patient / Insured*), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, identified below (as each, "Authorized Discloser", hereafter referred to as, "AD"), insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide PLUS Financial Network and/or Professional Life Settlements PLUS, LLC, its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers. (hereafter referred to as, "PFN"), any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV and/or AIDS, or drug or alcohol abuse, of or relating to the insured.

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 insured, 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 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.

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by PFN about my coverage.

I understand that the PFN will keep all information disclosed hereunder confidential and will only use the information for the purpose of obtaining a life insurance settlement. Furthermore, I understand that PFN will not release any information to any person or organization except as may be otherwise lawfully required or as I may further authorize; I also understand that this transaction requires PFN to re-disclosure the information to these necessary parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws; however PFN only works with companies that maintain the same HIPAA privacy standards. I acknowledge and understand that I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD, any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

I specifically authorize and request my insurance company and each AD to rely upon a photographic copy or facsimile copy or other reproduction of this Authorization. I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below I further certify that I have a full understanding of the Authorization's contents and I will retain a completed copy for future reference. I agree that this Authorization shall remain valid until and will expire on the date of my death or until the case is declined by PFN, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

_____

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

_____

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

_____	_____	_____
Signature of Patient / Insured	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date
_____	_____	_____
Signature of Policy Owner (*if not Insured*)	Printed Name	Date
_____	_____	_____
Signature of Witness	Printed Name	Date