Golden Life Settlements
3201 Nottingham Dr.
McKinney, Tx. 75070
Email- Inquiry@GoldenLifeSettlements.com

D/FW 972-529-9807
Toll Free 866-333-8975
Fax 972-325-1655

Only intended for residents of: AL, AZ, CA, DE, HI, ID, IL, MI, MN, MO, NH, NM, NY, OR, RI, SC, SD, VT, WA, WI, WV & WY.

Life Settlement Application

(Strictly Confidential Insurance Information)

Personal Data of the Insured:

Name of Insured: ____ Sex: Male Female

Date of Birth: _______-_________-__________ Social Security#:_________-______-_________

Current Address: ____

City: __________________________________ State: _________ Zip:________________

Telephone Numbers: Day: ______-_______-_________ Eve.: _______-_______-___________

Email Address: ____

Marital Status: Married Divorced Single Widowed Separated

Are you a United States citizen? Yes No

If divorced, did the divorce occur after the policy issue date? Yes No

Dependent Children? Yes No

Have you been or are you now a party to bankruptcy? Yes No

Are you the defendant in any legal suits or legal action? Yes No

If policy owner is different than the insured listed above:

Name of policy owner: ________________________________ Social Security # or Tax Id number __________________

Name of Trustee: ____

Current Address: ____

City: __________________________________ State: __________ Zip:________________

Telephone Numbers: Day: ______-________-_________ Eve.: ______-________-_________

Email Address: ____

Are you a United States citizen? Yes No

If divorced, did the divorce occur after the policy issue date? Yes No

Dependent Children? Yes No

Have you been or are you now a party to bankruptcy? Yes No

Are you the defendant in any legal suits or legal action? Yes No

Life Insurance Policy Information

Name of Insurance Company: ____

Policy Type: Whole Life Universal Life Group Term Other: ___________________

Policy Number: ______________________ Date Policy was Issued: __________________

Face Amount: ________________________ Premium Amount: ______________________

How often is Premium Paid? Monthly Quarterly Semi Annually Annually

When was the last premium paid? __________ When is the next premium due? __________

Cash value of the policy, if any: ____

Are there any outstanding loans against this policy? _________________________________

Beneficiary(ies):

Name: _____________________________ Relationship to Owner: ________________

Name: _____________________________ Relationship to Owner: ________________

Name: _____________________________ Relationship to Owner: ________________

Medical History – Please give a brief description of your medical condition

First Insured: ____

____

____

____

____

____

Second Insured:____

____

____

____

____

____

Primary Physician: ______________________________ Telephone #:________________________

Address: ____

City: _____________________________________ State: _________ Zip:__________________

Specialist: _____________________________________ Telephone #:________________________

Address: ____

City: _____________________________________ State: ________ Zip:__________________

Specialist: _____________________________________ Telephone #:________________________

Address: ____

City: _____________________________________ State: ________ Zip:__________________

For additional policy and/or physician information, please provide a supplementary page

Information required to obtain an offer:

Copy of the original life insurance policy.

Current in force illustration.

Medical records for the last 5 years, including family history(Golden Life Settlements can assist in obtaining medical records with your authorization and assistance).

Authorizations to release policy information and medical records - See Release Forms Below.

If policy owner has ever been bankrupt, include a copy of the bankruptcy discharge.

If policy owner has ever been divorced, include a copy of the divorce decree.

If the policy has been transferred include transfer documentation.

If policy owner is a trust, include a copy of the trust or Articles of Organization for a company.

Signature/s:

Signature of Policy Owner: ____

Printed Name: ____ Date: __________________

Signature of Joint Policy Owner, if applicable: ____

Printed Name: ____ Date: __________________

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Authorization for the Release of Life Insurance Policy Information

(Strictly Confidential Insurance Information)

Policy Owner: ____

Life Insurance Company: ____

Policy Number: ____

Insured: ____

I hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy, to release such information to and reply immediately to any written, telephone or other request for information or documents required by **Golden Life Settlements,** including, but not limited to the following:

- A fully-completed Verification of Coverage (VOC) form;
- A complete copy of the above-referenced life insurance policy, including the application (and also including the master policy and employee certificate for group policies);
- Policy Illustrations;
- Change of ownership forms, change of beneficiary forms, collateral assignment forms, absolute assignment forms and any other requested form; and
- Premium and Annual Statement information.

I understand that this Authorization for the Release of Life Insurance Policy Information will be used to gather information about the above-referenced life insurance policy to conduct and complete the evaluation, transfer, assignment, sale and/or resale of the above-referenced life insurance policy. I agree that this Authorization for the Release of Life Insurance Policy Information shall remain valid and in force for twenty-four (24) months from the date hereof absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder and that a photocopy or facsimile of this document is as valid as the original. The viator, life settlor or owner has the right to withdraw consent pursuant to applicable law. This document may be signed in counterparts.

Signature of Policy Owner: ____

Printed Name: ____ Date: _________________

Social Security # or Tax ID #: ____

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Authorization to Release Medical Information (HIPAA Compliant)

(Strictly Confidential Insurance Information)

Patient's (Insured's) Name: ____

Date of Birth: ________-_________-_________ Social Security #: _________-______-________

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

A. 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 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.

B. 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 to **Golden Life Settlements** (the "Authorized Recipient").

C. Description of Protected Health Information Authorized for Disclosure and the Purpose for such Disclosure: This 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 authorization 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 this life insurance policy under which my life is insured and (2) to verify, track and monitor my health and medical status and condition in connection with this life insurance policy under which my life is insured and which is sold.

D. Expiration of Authorization: I agree that this authorization shall remain valid for twenty-four (24) months from the date thereof absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under and that a photographic copy or facsimile of this Authorization shall be valid as the original.

E. Right to Revoke Authorization: I acknowledge and understand that I have the right to withdraw consent pursuant to applicable law and may revoke this authorization any time with respect to any Authorized Discloser and **Golden Life Settlements** (the "Authorized Recipient") by notifying such Authorized Discloser and **Golden Life Settlements** (the "Authorized Recipient") of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser and **Golden Life Settlements** (the "Authorized Recipient") provided that any revocation of this authorization shall not apply to the extent that the Authorized Discloser or **Golden Life Settlements** (the "Authorized Recipient") 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 "HIPAA 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 HIPAA Privacy Regulations.

I understand that this release form may be used to track on-going health status, and that the viator, life settlor or owner has the right to withdraw consent pursuant to applicable law.

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): ____

Printed Name of Patient(Insured): ______________________________ Date: ___________________

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BROKER OF RECORD LETTER

I appoint Golden Life Settlements to be the exclusive Broker of Record on the policy listed below.

Policy Owner:____

Life Insurance Company: ____

Policy Number: ____

Face amount: ____

I authorize and name Golden Life Settlements as the exclusive Life Settlement Broker to handle the valuation and brokerage of this policy. This enables Golden Life Settlements the ability to generate any and all potential offers from qualified Life Settlement Providers.

Signatures:

Signature of Policy Owner: ____

Printed Name: ____ Date: _________________

Social Security # or Tax ID #: ____

Signature of Broker of Record: ____

Printed Name: ____ Date: _________________