

## CASE SUBMISSION CHECKLIST

### Pre-Submission Checklist

- Application completed
- HIPAA/Medical Release completed
- Insurance Release completed
- Current Illustrations: Depending on type of policy
- Policy Owner information and state of residence provided in application
- Medical Records – last 5 years from both Primary Physician and Specialist

### Illustration Requirements

1. Run at current assumptions.
2. Show all loans paid in full in the current policy year.
3. Variable life illustrations should be shown with all values invested in the “Fixed Account Option.”
4. All illustrations should show accumulation values and/or cash values each policy year.

Additional requirements per policy type:

#### Universal Life:

1. Run one illustration with minimum level premium required to maintain level death benefit to age 100 with at least \$1000 at maturity.
2. Run one illustration with minimum level premium required to maintain level death benefit for ten full years, so it lapses in year eleven.
3. Run one zero premium illustration.

#### Whole Life:

1. Run one illustration showing premium offset in earliest possible year.
2. Run one illustration showing dividends applied to reduce premiums.
3. If policy has a term rider, the illustrations must show the full death benefit maintained to age 100.

#### Term Life:

1. Assume a conversion to the best available conversion product, preferably a Universal Life.

NOTE: In order to obtain the best possible offers for your clients, we may request additional illustrations.

### Contracts/Closing Items Checklist

- Original or Certified copy of insurance policy
- Copy of executed trust document
- Copy of insured photo ID
- Completed W-9
- Final verification of policy values by insurance carrier
- Letter of Competency may be required

### PERSONAL DATA

Insured's Name	Date of Birth	Sex: Male    Female	Social Security Number
2 <sup>nd</sup> Insured's Name	Date of Birth	Sex: Male    Female	Social Security Number
Insured's Address			Phone Number
City	State	Zip	

Is Client Applying For New Insurance? Yes    No
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### LIFE INSURANCE POLICY INFORMATION – POLICY # 1

Insurance Company	Policy Number	Issue Date
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$
Current Cash Surrender Value \$	Policy Type: Universal Life    Whole Life    Variable Life    Term    Survivorship	
Policy Owner	Owner's Social Security Number or Tax ID	
Owner's Permanent Address		
City	State	Zip
Beneficiary	Has the policy Owner ever declared bankruptcy? Yes    No	

### LIFE INSURANCE POLICY INFORMATION – POLICY # 2

Insurance Company	Policy Number	Issue Date
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$
Current Cash Surrender Value \$	Policy Type: Universal Life    Whole Life    Variable Life    Term    Survivorship	
Policy Owner	Owner's Social Security Number or Tax ID	
Owner's Permanent Address		
City	State	Zip
Beneficiary	Has the policy Owner ever declared bankruptcy? Yes    No	

### FRAUD WARNING

**ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT/VIATICAL SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

### INSURED MEDICAL INFORMATION

Insured Medical History and Conditions		
Primary Physician		Date and Reason Last Seen
Address		Telephone
City	State	Zip
Insured's Specialist		Date and Reason Last Seen
Address		Telephone
City	State	Zip

### 2<sup>nd</sup> INSURED MEDICAL INFORMATION

2 <sup>nd</sup> Insured Medical History and Conditions		
Primary Physician		Date and Reason Last Seen
Address		Telephone
City	State	Zip
2 <sup>nd</sup> Insured's Specialist		Date and Reason Last Seen
Address		Telephone
City	State	Zip

### PLEASE LIST OTHER INFORCE LIFE INSURANCE POLICIES ON INSURED

Insurance Company	Face Amount \$
Insurance Company	Face Amount \$
Insurance Company	Face Amount \$

### NOTICE TO APPLICANTS

Applicant has a clear and complete understanding of the current or future benefits of the life insurance policy being offered for sale or viatical settlement. Applicant acknowledges that he/she has freely and voluntarily provided the information requested in this application.

\_\_\_\_\_  
NAME OF APPLICANT

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
DATE



**Authorization for Disclosure of Protected Health Information**

The undersigned insured(s) (hereafter referred to as “I”, “me” or “my”), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an “HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Paul W. Bowen, to any viatical settlement company designated by Paul W. Bowen including, but not limited to: any medical underwriting services designated by Paul W. Bowen and any of the protected health information retrieval services designated by Paul W. Bowen. I understand that my PHI may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website.

3. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any other viatical settlement provider, or their affiliates, subsidiaries, or corporate parents purchases.

4. Expiration of Authorization: This authorization shall remain valid until one (1) year after 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 HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I 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, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

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NAME OF INSURED

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SIGNATURE OF INSURED

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NAME OF WITNESS

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SIGNATURE OF WITNESS

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NAME OF SECOND INSURED

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SIGNATURE OF SECOND INSURED

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NAME OF WITNESS

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SIGNATURE OF WITNESS

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SIGNED AT: CITY

STATE

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DATE

**Notice of Disclosure**

Pursuant to Section 83-7-215, the viator should be aware of the following disclosures.

1. Possible alternatives exist to viatical settlement contracts for individuals with catastrophic, life threatening or chronic illnesses including any accelerated death benefits offered under the viator's life insurance policy.
2. Some or all of the proceeds of the viatical settlement may be free from federal income tax and from state franchise and income taxes, and assistance should be sought from a professional tax advisor.
3. Proceeds of the viatical settlement could be subject to the claims of creditors.
4. Receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
5. The viator has the right to rescind a viatical settlement contract fifteen (15) calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in Section 9(3) of this act.
6. Funds will be sent to the viator within two (2) business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to the viatical settlement contract.
7. 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 assistance should be sought from a financial adviser.

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NAME OF INSURED

SIGNATURE OF INSURED

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NAME OF VIATOR (IF OTHER THAN INSURED)

SIGNATURE OF VIATOR

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SIGNED AT: CITY

STATE

DATE