

ELA Settlement Services, LLC Data Collection Form

Complete the following forms, and mail, fax or email with any relevant documents to:

ELA Settlement Services
1435 Morris Ave. • P.O. Box 3137 • Union, NJ 07083
Fax: 908-810-4159 • Tel 1-800-388-0103 • email: info@execlife.com

After receiving the following information, we will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign pages in the areas indicated.

INSURED'S INFORMATION

Insured's Name _____
Social Security # _____ - _____ - _____
Street Address (No PO Box) _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Fax # _____ E-mail Address _____
Date of Birth _____ Sex Female Male
Spouse's Full Name _____
Spouse's Date of Birth _____ / _____ / _____

EMPLOYMENT STATUS

Are you currently retired? Yes No Do you work? Yes No
Current employer and occupation _____

LIFE INSURANCE POLICY INFORMATION

(please provide for each policy being offered for sale)

Name of Insurance Company _____
Policy Number _____ Face Value \$ _____
Policy Issue Date _____ Insuring Individual Survivorship
Policy Type - Universal VUL Term Whole Life Group
If term policy, can it be converted until what date? _____
Did anyone other than the owner pay for or finance premium payments? Yes No
Annual Premium _____ Paid A SA Q M
Next premium due date _____
Owner of Policy _____ Tax ID# _____
Owner Address _____
Phone _____ Fax _____
Complete Trust or Corporation name, and names of Trustee(s) or 2 officers

Beneficiary (ies) _____
Primary Beneficiary Address _____

Reason for selling _____
Has an application for insurance on insured's life/health ever been declined,
rated or modified in any way (including this policy)? Yes No
If yes, give company and reason _____

Does the insured have plans to purchase new life insurance? _____
Total face value of life insurance NOT being offered for sale herewith _____

MEDICAL

Please list any specific health conditions _____

Has insured smoked: Cigarettes Cigars Cigarillos Pipe in past 12 months? No

Does insured use or has ever used alcoholic beverages? Yes No If yes, answer the following:

(A) Frequency of use Daily Weekly Monthly Occasionally

(B) Amount consumed on each occasion _____

(C) Any treatment for alcohol use (including AA treatment) _____

FAMILY HISTORY	<u>Current Age</u>	<u>Deceased?</u>	<u>If deceased, cause and age at time of death</u>
(A) Father _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
(B) Mother _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
(C) (Brother) (Sister) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
(D) (Brother) (Sister) _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please list insured's Primary Care Physician:

1) Name _____	3) Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____
	Specialty: _____
	Date last seen: _____

Please list Specialists that insured has seen:

2) Name _____	4) Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone # _____	Phone # _____
Specialty: _____	Specialty: _____
Date last seen: _____	Date last seen: _____

Attach additional pages if needed. Give a copy of the letter enclosed to the above physicians/specialists (make copies as needed).

FINANCIAL

Has insured applied for or received a pension or compensation because of illness or injury? Yes No

If yes, give details of illness or injury: _____

Has owner been a party to a: (check all that apply) Civil Suit
 Bankruptcy Judgments Creditor Liens Tax Liens

Explain any checked answers on a separate page and attach all discharge papers.

Does insured have a living will? Yes No

PERSONAL ACKNOWLEDGEMENT

I represent and warrant that the information contained in this data collection form is correct and accurate and you may rely thereon and that I will immediately notify ELA Settlement Services of any changes in the information. I further give my consent to ELA Settlement Services 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 purchase of my life insurance policy. I acknowledge that I am submitting this data collection form for ELA Settlement Services to evaluate the purchase of my life insurance policy and that ELA Settlement Services is under no obligation to purchase my policy. I acknowledge I may be contacted by ELA Settlement Services regarding the information contained in this data collection form.

I understand that some or all of the proceeds from a life 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 ELA Settlement Services nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

Owner's signature _____

Typed or printed name _____ Date _____

Witness signature _____

Printed Name _____ Date _____

Insured's Name: _____ Social Security: ____ - ____ - ____

Connecticut Disclosure Statement

1. There are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.
2. Some or all of the proceeds of the viatical settlement may be taxable under federal income tax, and assistance should be sought from a professional tax advisor.
3. Receipt of the viatical settlement proceeds may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate governmental agencies or advisors.
4. The viatical settlement provider may assign or otherwise transfer its interest in the viaticated policy to a third party.
5. The viator has the right to rescind a viatical settlement contract for fifteen calendar days after the receipt of the viatical settlement proceeds by the viator. Such rescission shall be effective only if both notice of rescission is delivered by the viator to the viatical settlement provider and a full return of funds to the viatical settlement provider is made before the expiration of the applicable rescission period, as provided in subsection (c) of section 38a-465g. 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 and any premiums, loans and loan interest to the viatical settlement provider or viatical settlement purchaser.
6. Proceeds of the viatical settlement may be subject to the claims of general creditors.
7. Funds will be sent to the viator within two business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the viatical policy or interest in the certificate has been transferred and the beneficiary has been designated pursuant to sections 38a-465 to 38a-465q, inclusive.
8. Entering into a 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.
9. The insured may be contacted by either the viatical settlement provider or broker or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every three months following the date the viatical settlement proceeds are released to the viator if the insured has a life expectancy of more than one year, and no more than once per month following such date if the insured has a life expectancy of one year or less.
10. Disclosure to a viator shall include distribution of a brochure developed or authorized by the commissioner describing the process of viatical settlements.
11. All medical, financial, or personal information solicited or obtained by a viatical settlement company or viatical settlement broker about a viator and an insured, including the viator and insured's identity of family members, a spouse or a significant other is confidential. 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 this information every two years.

I (We) acknowledge receipt of this Disclosure Statement as well as a separate brochure describing the process of viatical settlements.

Date

Owner's Signature

Owner's Signature

Date

ELA Settlement Services, 1435 Morris Ave, PO Box 3137, Union, NJ 07083

**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION**

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

I authorize any physician, doctor, physician practice group, medical practitioner, nurse, nurse practitioner, hospice, hospital clinic or other medical or medically-related facility, insurance support organization, pharmacy, or any other institution or person (“Authorized Discloser”) to provide ELA Settlement Services, LLC, or its designee (“Authorized Recipient”) any and all of my PHI as provided under this authorization. This may include information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me.

This authorization allows for the disclosure, inspection, and copying of any and all records, reports, consultations, and/or documents, including any underlying data regarding my care and treatment, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to me, along with any and all medical charts, clinical or doctor’s notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, medical records in the possession and control of the Authorized Discloser. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site.

This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition. The Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this authorization.

I understand that I have a right to revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of the revocation in writing and presenting my written revocation in person or by certified mail to such address designated by the respective Authorized Discloser. I understand that the revocation will not apply to information that has already been released in response to 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 care plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the “HIPAA Privacy Regulations”) and that PHI obtained by this Authorization, if re-disclosed by the 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. I agree this authorization is valid for one (1) year from the date of this signature, and that a photocopy or facsimile is as valid as an original.

Signature of patient or legal representative

Date

Printed name of patient

If signed by legal representative,
relationship to patient

Signature of witness

Date

**AUTHORIZATION FOR RELEASE AND USE OF MEDICAL
AND/OR INSURANCE INFORMATION**

I hereby authorize any physician, medical practitioner, hospice, clinic or other medical or medically related facility, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide ELA Settlement Services, LLC and/or its authorized representatives or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, 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 or control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency reinsurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby authorize such use and disclosure. 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 the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), 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.

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

CHECKLIST FOR DATA COLLECTION FORM PACKAGE

This checklist was designed to help you ascertain if you have completed all pertinent items in order to expedite processing of the life settlement.

The following items must be received by ELA Settlement Services in order for the policy to be processed:

- Data Collection Form must be filled out completely, signed and witnessed. Anything that is not applicable, mark "N/A."
- The release forms for Medical and Policy Information must be signed, witnessed and dated by appropriate parties as indicated.
- The Notice of Disclosure must be signed and dated.
- 5 years of medical records for attending physicians, current within 30 days of completing the Data Collection form.
- Agent of Record Letter signed, dated and witnessed.
- Insured's photo ID - Accepted forms of identification are photocopies of a driver's license or passport. Identification must be current not expired.
- Complete copy of the insurance policy. If this is not available immediately, please make a note for us on the Data Collection Form and forward as soon as possible.
- Current in-force illustration from the insurance company with Data Collection Form showing the following:
 - Universal Life - minimum premium payment to age 95.
 - Term - proposed conversion illustration to Universal showing a minimum payment to age 95.
 - Whole Life - run a natural vanish premium illustration to age 95.
- Owner and Beneficiary (ies) of the policy.
 - If owner/beneficiary is a trust, we need:
 - Copy of trust and Tax ID#
 - Trustee (s) must sign the policy information release form
 - If owner/beneficiary is a corporation, we need:
 - Complete name and address of corporation.
 - Corporate resolution showing current authorized officers.
 - Two officers must sign the policy information release form.

In addition, please send the "Letter to Physician" directly to the physicians/ specialists listed on the application.

FOR AGENTS ONLY: Broker _____

Representing Agent _____

Address _____

Phone _____ Fax _____

Is the representing agent the agent of record on the policy? _____

Agent Signature _____ Date _____

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