

# 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

Are there supplemental benefits such as Accidental Death or Double Indemnity provision on the Policy?  Yes  No

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) \_\_\_\_\_

<b>FAMILY HISTORY</b>	<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.

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

Owner's signature \_\_\_\_\_

Typed or printed name \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

### Connecticut Disclosure Statement

**The Provider must provide these disclosures not later than the date the settlement contract is signed by all parties.**

1. That there are possible alternatives to life settlement contracts including, but not limited to, accelerated death benefits offered by the issuer of the life insurance policy;
2. That some or all of the proceeds of a life settlement contract may be taxable, and assistance should be sought from a professional tax advisor;
3. That receipt of the life settlement contract proceeds may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements, and advice should be obtained from the appropriate agencies;
4. That the owner has the right to rescind a life settlement contract for fifteen calendar days after the date such contract is executed by all parties and the owner has received the disclosures specified herein. Such rescission exercised by the owner shall be effective only if both notice of rescission is given to the provider and the owner repays all proceeds and any premiums, loans and loan interest paid by the provider within the rescission period. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the provider;
5. That proceeds from the life settlement contract may be subject to the claims of creditors;
6. That proceeds will be sent to the owner within three business days after the 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 in accordance with the terms of the life settlement contract;
7. That entering into a life 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 owner, and assistance should be sought from a financial advisor;
8. That the insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;
9. The amount and method of calculating the compensation paid or to be paid to the broker or to any other person acting for the owner in connection with the transaction, wherein the term compensation includes anything of value paid or given;
10. The date by which the funds will be available to the owner and the transmitter of the funds;
11. That the commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process;
12. That the commissioner shall require providers and brokers to print separate, signed fraud warnings on their applications and on their life settlement contracts as follows: "Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.";
13. The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;
14. That a broker represents the owner exclusively, and not the insurer, the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;
15. The name, address and telephone number of the provider;
16. The name, business address and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and
17. That a change of ownership could limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.
18. A broker shall provide the owner and the provider with at least the following disclosures not later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:
  - (a.) The name, business address and telephone number of the broker;
  - (b.) A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed life settlement contract;

- (c.) A written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract;
- (d.) The name of each broker who receives compensation and the amount of compensation received by said broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract;
- (e.) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this section, "gross offer" or "bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and
- (f.) That the failure to provide the disclosures or rights described in this section shall be deemed an unfair practice in violation of section 38a-815.

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

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**AUTHORIZATION FOR THE RELEASE OF INFORMATION  
RELEASE OF POLICY INFORMATION**

**Please complete only the areas marked with asterisk.**

I hereby authorize \_\_\_\_\_, the issuer of Policy Number \_\_\_\_\_ and/or Certificate Number \_\_\_\_\_ owned by \_\_\_\_\_ and insuring the life of \_\_\_\_\_, to release to ELA Settlement Services or its authorized agents, a copy of the policy, forms, riders or amendments of this policy. I respectfully request that you reply immediately to any request for information or letters required by ELA Settlement Services or its agents pertaining to this policy or employment information. I agree that this authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

\_\_\_\_\_  
\*Signature of Owner

\_\_\_\_\_  
\*Printed Name of Owner

\_\_\_\_\_  
\*Date Signed

\_\_\_\_\_  
\*Social Security Number

\_\_\_\_\_  
\*Signature of Witness

\_\_\_\_\_  
\*Printed Name of Witness

\_\_\_\_\_  
\*Date Signed

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**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

**AGENT OF RECORD LETTER  
FOR LIFE SETTLEMENTS**

I, \_\_\_\_\_, owner of policy number \_\_\_\_\_  
with \_\_\_\_\_ insurance company, have agreed  
to consider the sale of this policy as a Life Settlement.

My agent of record for the sale of the above mentioned policy is:

\_\_\_\_\_

and settlement agency of record is ELA Settlement Services, LLC.

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness

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**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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