ELA Settlement Services, LLC Application

Complete the following application and mail to:

ELA Settlement Services
1435 Morris Ave. • P.O. Box 3137 • Union, NJ 07083
or fax to 908-810-4159 • Tel 1-800-388-0103

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 __________

A Proud Member of LISA® THE LIFE INSURANCE SETTLEMENT ASSOCIATION

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	Current Age	Deceased?	If deceased, cause and age at time of death
(A) Father	______	❑ Yes ❑ No	______
(B) Mother	______	❑ Yes ❑ No	______
(C) (Brother) (Sister)	______	❑ Yes ❑ No	______
(D) (Brother) (Sister	______	❑ Yes ❑ No	______

Please list insured's Primary Care Physician:

1) Name ______

Address ______

City, State, Zip ______

Phone # ______

Date Last Seen: ______

3) Name ______

Address ______

City, State, Zip ______

Phone # ______

Specialty: ______

Date last seen: ______

Please list Specialists that insured has seen:

2) Name ______

Address ______

City, State, Zip ______

Phone # ______

Specialty: ______

Date last seen: ______

4) Name ______

Address ______

City, State, Zip ______

Phone # ______

Specialty: ______

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 application 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 application 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 application 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 application.

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 ______

MEDICAL INFORMATION FOR THE INSURED

Insured Name ________________________ Insured's Phone Number: ________________________

1. In your own words, please provide a status of the present health condition of the insured along with any details of any medical impairments. Please also specify all medication currently being taken including the frequency and dosage of such medication. (please use continuation sheet if necessary and complete a second sheet of this page for the second insured - if applicable).

I certify that the above is a full and accurate description of my current health situation and that by signing below I indicate my authorization for a telephone medical interview as part of this underwriting process to sell this policy.

Insured Name ____ Date ________________________

Insured's Name: ____________________Social Security: ____ - ____ - ____

NOTICE OF DISCLOSURE

1. There may be alternatives to a life settlement contract including, but not limited to, accelerated benefits, loans secured by the policy, and surrender of the policy for cash value 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 carrier and/or policy. We encourage you to contact the issuer of your policy to discuss these other benefits.
2. Some or all of the proceeds of your life settlement may be taxable under federal income tax and/or state franchise and income tax laws. ELA Settlement Services strongly urges you to consult your own attorney or tax advisor concerning this transaction. ELA Settlement Services 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 your life settlement proceeds may adversely affect your eligibility for social security income, public assistance, public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Proceeds from a life settlement may not be exempt from claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents or others, there may be a loss of coverage. We urge you to contact the issuer of your life insurance policy for information on these provisions.
6. Entering into a life settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy to be forfeited by you.
7. All medical, financial or personal information solicited or obtained by ELA Settlement Services about the insured, including the insured's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the life settlement between you and ELA Settlement Services. If the insured is asked to provide this information, the insured will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. The insured may be asked to renew his or her permission to share information every two years.
8. The insured may be contacted by ELA Settlement Services or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months.
9. Funds will be sent to you within three (3) business days after ELA Settlement Services has received the insurer's or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
10. You have the right to rescind a life settlement contract for a period of (15) calendar days after your receipt of the proceeds. If the insured dies during the recession period, the settlement contract shall be deemed rescinded.
11. You are encouraged to contact an attorney, accountant, financial planning advisor, insurer, tax advisor or social services agency regarding potential consequences resulting from entering into a life settlement.

I acknowledge that I have read and understand the contents of this disclosure.

Owner's Signature ____Date ______________________________

Typed or Printed Name ____

State of ____ County of ______________________________

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

1435 Morris Avenue
P.O. Box 3137,
Union, NJ 07083-1937
Phone: 800-388-0103
Fax: 908-810-4159

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**, a Life Settlement Wholesaler, any of the following information if requested by them.

- **A fully completed Verification of Coverage Form (VOC)**
- **A complete copy of the above mentioned policy**
- **Policy illustrations**
- **Premium and Annual Statement Information**

I respectfully request that you reply immediately to any request for information or letters required by **ELA Settlement Services** 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 ____

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

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

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 re-insurers 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

BROKER CHECKLIST FOR APPLICATION 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 Application to be processed.

- ❏ Application 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 60 days of application. If not in your possession, ELA Settlement Services will order.
- ❏ 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. ID must be current, not expired.
- ❏ Complete copy of the insurance policy or Spec. page. If this is not available immediately, please advise in your cover letter and forward to ELASS as soon as possible.
- ❏ Current in-force illustration from the insurance company with application showing the following (if you are not the Agent of Record, ELASS will order):
- ❏ Universal Life – minimum premium payment to policy maturity.
- ❏ Term – proposed conversion illustration to Universal showing a minimum payment to policy maturity.
- ❏ Whole Life – run a natural vanish premium illustration to policy maturity.
- ❏ Owner and Beneficiary (ies) of the policy.

  If owner/beneficiary is a trust, we need:

  - ❏ Copy of trust and Tax ID#
  - ❏ One Trustee must sign the policy information release form

  If owner/beneficiary is a corporation, we need:

  - ❏ Complete name and address of corporation
  - ❏ Two officers must sign the policy information release form

FOR AGENTS ONLY: Broker______________________________

Address:______________________________

Phone:____________________ Fax:____________________

E-Mail:______________________________

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

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