

## LIFE SETTLEMENT APPLICATION

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

### PERSONAL DATA

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NAME OF FIRST INSURED	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
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NAME OF SECOND INSURED	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
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ADDRESS

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CITY	STATE	ZIP
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REASON FOR SALE

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FIRST INSURED MEDICAL CONDITION (BRIEF DESCRIPTION)

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SECOND INSURED MEDICAL CONDITION (BRIEF DESCRIPTION)

### LIFE INSURANCE POLICY INFORMATION

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INSURANCE COMPANY	POLICY NUMBER	ISSUE DATE
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FACE AMOUNT	ACCOUNT VALUE	CASH SURRENDER VALUE
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ANNUAL PREMIUM PAYMENT	NEXT PREMIUM DUE DATE	TOTAL POLICY LOAN
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LAST PREMIUM PAID DATE	AMOUNT PAID
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ANNUAL       SEMI-ANNUAL       QUARTERLY       MONTHLY

PREMIUM MODE

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TERM       UL       WL       SUL       SWL       VUL       OTHER (please specify)

TYPE OF POLICY

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INDIVIDUAL       GROUP       CONVERTED GROUP

GROUP OR INDIVIDUAL POLICY

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NO       YES (provide details):

HAS THE OWNERSHIP OF THE POLICY CHANGED SINCE ITS ORIGINAL ISSUE?

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NO       YES (provide details):

HAS THE POLICY EVER BEEN SUBJECT TO A NON-RECOURSE PREMIUM FINANCE LOAN?

***POLICYOWNER(S)***

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NAME OF POLICYOWNER(S) SOCIAL SECURITY OR TAX ID NUMBER

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NAME OF PRESIDENT (IF CORPORATE OWNED) NAME OF CORPORATE SECRETARY

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NAME OF TRUSTEE (S) (IF TRUST OWNED) DATE OF TRUST

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ADDRESS

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CITY STATE ZIP

If individually owned, has Policyowner ever been? (check all that apply)

Married  Divorced  Legally Separated  Widowed  Bankrupt

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If more than one policy is being submitted, please attach an additional page including Policyowner(s) and life insurance policy information as requested above.

**MEDICAL INFORMATION**

***FIRST INSURED***

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NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

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ADDRESS

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CITY STATE ZIP

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NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

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ADDRESS

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CITY STATE ZIP

***SECOND INSURED***

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NAME OF PRIMARY PHYSICIAN \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

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ADDRESS \_\_\_\_\_

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CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

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NAME OF SPECIALIST PHYSICIAN \_\_\_\_\_ SPECIALTY \_\_\_\_\_ TELEPHONE WITH AREA CODE \_\_\_\_\_

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ADDRESS \_\_\_\_\_

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CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

If there are any other physicians who have treated the Insured(s) in the last five years, please attach an additional page including full name of physician(s), specialty, address and telephone number with area code.

***The following will be needed to obtain an offer:***

- Copy of the insurance policy and current statement of values
- In-force illustrations showing zero cash value at maturity:
  - If Universal Life policy, submit minimum premium payments
  - If Term policy, submit a current illustration and a conversion illustration to a permanent policy showing minimum premium payments
  - If Whole Life policy, submit a vanishing premium illustration

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SIGNATURE OF FIRST INSURED \_\_\_\_\_ DATE \_\_\_\_\_

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SIGNATURE OF SECOND INSURED (IF APPLICABLE) \_\_\_\_\_ DATE \_\_\_\_\_

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SIGNATURE OF POLICYOWNER(S) \_\_\_\_\_ DATE \_\_\_\_\_

**AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION (signed by the Insured(s) and Policyowner(s))**

I/We hereby authorize any physician, medical practitioner, hospital, clinic or any other medical facility, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer, benefits plan administrator, or any other institution or person to provide Q Capital Strategies, LLC (“Q Capital”) and/or its authorized representatives, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition of the Insured(s) including psychiatric condition, or drug and alcohol abuse.

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(s) 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(s), along with any and all medical bills in your possession and control.

I/We understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the life insurance policy(ies) on which I/We are the Policyowner(s) or Insured(s) and which are the subject of the Life Settlement Application with Q Capital.

This Authorization allows Q Capital and its authorized representatives to use the medical or insurance information, and to disclose such information to Q Capital’s funding sources and their medical underwriters and/or contingency reinsurers. The receipt, use and disclosure of the information obtained pursuant to this Authorization is for the purpose of pursuing and completing the sale of life insurance policy(ies) on which I/We are the Policyowner(s) or Insured(s), and permitting Q Capital to obtain any amounts payable to the owner or beneficiary of the Policy(ies). I/We hereby expressly authorize such receipt, use and disclosure.

I/We agree that a photographic copy or facsimile of this Authorization shall be valid as the original. A valid authorization to disclose nonpublic personal health information shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months. I/We agree that this Authorization shall remain valid for twenty-four (24) months, 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. I/We understand that all medical information will be kept strictly confidential and will not be released to the Medical Information Bureau. I/We understand that this Authorization may be revoked at any time by submitting a written revocation to Q Capital at its address set forth in this Authorization, or to such other persons or addresses as Q Capital shall furnish to you in writing. Such written revocation must indicate the date that the Authorization is to be revoked, which date shall be on or after the date of the written revocation.

NAME OF FIRST INSURED	SIGNATURE	DATE
NAME OF SECOND INSURED	SIGNATURE	DATE
NAME OF POLICYOWNER(S)	SIGNATURE	DATE
NAME OF WITNESS	SIGNATURE	DATE
NAME OF WITNESS	SIGNATURE	DATE

**PHOTOCOPIES AND/OR FACSIMILES OF THIS DOCUMENT SHALL BE AS VALID AS THE ORIGIN**

**AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION**

(signed by the Policyowner(s))

I/We hereby authorize the insurance company to release directly to Q Capital Strategies, LLC (“Q Capital”) and/or its authorized representatives any and all information and forms in connection with the policy(ies) listed below (including, but not limited to, verification of coverage, any illustrations or any conversions, thereat). As per my/our specific instructions as the Policyowner(s), please fax the requested information to Q Capital directly and forward a copy to the undersigned Policyowner(s).

I/We agree that a photographic copy or facsimile of this Authorization shall be valid as the original.

I/We agree that this Authorization shall remain valid for three years, 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.

NAME OF POLICYOWNER(S) SIGNATURE DATE

ADDRESS SOCIAL SECURITY OR TAX ID NUMBER

CITY STATE ZIP

POLICY NUMBER 1 INSURANCE COMPANY

POLICY NUMBER 2 INSURANCE COMPANY

POLICY NUMBER 3 INSURANCE COMPANY

NAME OF WITNESS SIGNATURE DATE

NAME OF WITNESS SIGNATURE DATE

**PHOTOCOPIES AND/OR FACSIMILES OF THIS DOCUMENT SHALL BE AS VALID AS THE ORIGINAL**

**PERSONAL ACKNOWLEDGEMENT**

(signed by the Policyowner(s))

I/We represent and warrant that (a) the information contained in this Application is correct and accurate, (b) that Q Capital Strategies, LLC (“Q Capital”), and its authorized representatives, funding sources, medical underwriters and contingency reinsurers, may rely thereon and (c) I/We will immediately notify Q Capital of any changes in the information. I/We further give consent to Q Capital, and its authorized representatives, to disclose this Application and any information gathered while processing it as necessary for the purpose of completing the sale of the life insurance policy(ies) listed herein and permitting Q Capital to obtain any amounts payable to the owner or beneficiary of the Policy(ies). I/We acknowledge that I/We are submitting this Application to Q Capital to evaluate the sale of the life insurance policy(ies) listed herein and that Q Capital is under no obligation to purchase the policy(ies). I/We acknowledge that Q Capital may contact me/us regarding information contained in this Application. I/We understand that the consents in this Acknowledgement may be revoked at any time by submitting a written revocation to Q Capital its address set forth in this Acknowledgement indicating the date that the consents are to be revoked, which date shall be on or after the date of the written revocation.

A valid authorization to disclose nonpublic personal health information shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more then twenty-four (24) months.

Possible alternatives to a life settlement contract may exist, including, but not limited to, nonforfeiture options offered by the issuer of your policy.

Some or all of the sale proceeds of a life settlement may be taxable. You should seek advice from a professional tax advisor.

A life settlement may be subject to creditors’ claims.

Receipt of a life settlement may adversely affect the recipient’s eligibility for Medicaid or other government benefits or entitlements. You should seek advice from the appropriate agency.

When you enter a life settlement, funds will be sent to you from an escrow agent immediately in a lump sum by wire transfer or certified check after the escrow agent receives an acknowledgement from your life insurer that ownership of your policy has been transferred, and the beneficiary designation has been changed, as required by the life settlement contract.

Contacts for the purpose of determining the health status of the insured after the life settlement has occurred shall be limited to no more than once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than once per month for insureds with a life expectancy of one (1) year or less. Such contacts will be by mail.

In the event that your life insurance policy contains a provision for double or additional indemnity for accidental death of the insured, the additional payment shall remain payable to the beneficiary last named by you prior to entering into the life settlement contract, or to such other beneficiary, other than Q Capital, as you may designate after entering into the life settlement contract, or, in the absence of a beneficiary designation, to your estate.

You have the right to rescind a life settlement contract within thirty (30) days after it is executed by all parties or within fifteen (15) days from the date that you receive the life settlement proceeds, whichever is less.

NAME OF POLICYOWNER(S) SIGNATURE DATE

NAME OF WITNESS SIGNATURE DATE