

POLICY OWNER(S)

NAME OF POLICY OWNER(S) SOCIAL SECURITY OR TAX ID NUMBER

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

NAME OF MANAGER (IF LLC OWNED)

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

ADDRESS

CITY STATE ZIP

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

Married Divorced Legally Separated Widowed Bankrupt

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

MEDICAL INFORMATION

FIRST INSURED

NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

ADDRESS

CITY STATE ZIP

SECOND INSURED

NAME OF PRIMARY PHYSICIAN

TELEPHONE WITH AREA CODE

ADDRESS

CITY

STATE

ZIP

NAME OF SPECIALIST PHYSICIAN

SPECIALTY

TELEPHONE WITH AREA CODE

ADDRESS

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

SIGNATURE OF FIRST INSURED

DATE

SIGNATURE OF SECOND INSURED (IF APPLICABLE)

DATE

SIGNATURE OF POLICY OWNER(S)

DATE

AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION
(signed by the Policy Owner(s))

I/We hereby authorize the insurance company to release directly to Q Capital Strategies, LLC and/or its authorized representatives or assignees 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 Policy Owner(s), please fax the requested information to Q Capital Strategies, LLC directly and forward a copy to the undersigned Policy Owner(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 POLICY OWNER(S)	SIGNATURE	DATE
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ADDRESS	SOCIAL SECURITY OR TAX ID NUMBER
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CITY	STATE	ZIP
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POLICY NUMBER 1	INSURANCE COMPANY
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POLICY NUMBER 2	INSURANCE COMPANY
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POLICY NUMBER 3	INSURANCE COMPANY
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NAME OF WITNESS	SIGNATURE	DATE
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NAME OF WITNESS	SIGNATURE	DATE
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PHOTOCOPIES AND/OR FACSIMILES OF THIS DOCUMENT SHALL BE AS VALID AS THE ORIGINAL

PERSONAL ACKNOWLEDGEMENT

(signed by the Policy Owner(s))

I/We represent and warrant that (a) the information contained in this Application is correct and accurate, (b) that Q Capital Strategies, LLC, and its authorized representatives and assignees, and their funding sources and their medical underwriters, contingency insurers and reinsurers and purchasers of life insurance policies may rely thereon and (c) I/We will immediately notify Q Capital Strategies, LLC of any changes in the information. I/We further give consent to Q Capital Strategies, LLC, and its authorized representatives or assignees, to disclose this Application and any information gathered while processing it as necessary for the purpose of completing the sale and resale of the life insurance policy(ies) listed herein and permitting Q Capital Strategies, LLC or any subsequent Policy Owner(s) to obtain any amounts payable to them as owner or beneficiary of the Policy(ies). I/We acknowledge that I/We are submitting this Application to Q Capital Strategies, LLC to evaluate the sale of the life insurance policy(ies) listed herein and that Q Capital Strategies, LLC is under no obligation to purchase the policy(ies). I/We acknowledge that Q Capital Strategies, LLC may contact me/us regarding information contained in this Application.

The Acknowledgement set forth above is made to Q Capital Strategies, LLC, and deemed to be made to each subsequent owner of the Policy and any party who is a potential purchaser of the Policy from any subsequent owner.

I/We understand that some or all of the proceeds from a Viatical Settlement may be taxable and that I/We are encouraged to consult with an attorney or tax advisor concerning this transaction. I/We also acknowledge that neither Q Capital Strategies, LLC nor any of its affiliates or representatives has made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

NAME OF POLICY OWNER(S)	SIGNATURE	DATE
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NAME OF WITNESS	SIGNATURE	DATE
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