Q Capital Strategies

INFO@QCAPITAL.COM

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION **(signed by the Insured(s) and Policy Owner(s)/Viator(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 and/or its authorized representatives or assignees 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 personal information and insurance policy information, including but not limited to, forms, riders and amendments concerning the life insurance policy(ies) on which I/We are the Policy Owner(s)/Viator(s) or Insured(s).

This Authorization allows Q Capital Strategies, LLC and its authorized representatives and assignees to use the medical or insurance information, and to disclose such information to their funding sources, medical underwriters, insurers and contingency reinsurers. The Authorization set forth is granted to Q Capital Strategies, LLC, each subsequent owner of the Policy, and any party who is a potential purchaser of the Policy from any subsequent owner. The receipt, use and disclosure of the information obtained pursuant to this Authorization is for the purpose of pursuing and completing the sale or resale of life insurance policy(ies) on which I/We are the Policy Owner(s)/Viator(s) or Insured(s), and permitting Q Capital Strategies, LLC, or any subsequent Policy Owner(s) 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. I/We agree that this Authorization shall remain valid for the lifetime of the undersigned Insured (or the last to survive if more than one undersigned Insured), 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.

NAME OF FIRST INSURED	SIGNATURE	DATE
NAME OF SECOND INSURED	SIGNATURE	DATE
NAME OF POLICY OWNER(S)/VIATOR(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 ORIGINAL

AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION

(signed by the Policy Owner(s)/Viator(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, thereof). As per my/our specific instructions as the Policy Owner(s)/Viator(s), please fax the requested information to Q Capital Strategies, LLC directly and forward a copy to the undersigned Policy Owner(s)/Viator(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)/VIATOR(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