Q Capital Strategies

INFO@QCAPITAL.COM

LIFE SETTLEMENT APPLICATION

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

PERSONAL DATA

NAME OF FIRST INSURED | DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER

NAME OF SECOND INSURED | DATE OF BIRTH | SEX | SOCIAL SECURITY NUMBER

ADDRESS

CITY | STATE | ZIP

REASON FOR SALE

FIRST INSURED MEDICAL CONDITION (BRIEF DESCRIPTION)

SECOND INSURED MEDICAL CONDITION (BRIEF DESCRIPTION)

LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY | POLICY NUMBER | ISSUE DATE

FACE AMOUNT | ACCOUNT VALUE | CASH SURRENDER VALUE

ANNUAL PREMIUM PAYMENT | NEXT PREMIUM DUE DATE | TOTAL POLICY LOAN

LAST PREMIUM PAID DATE | AMOUNT PAID

☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY ☐ MONTHLY

PREMIUM MODE

☐ TERM ☐ UL ☐ WL ☐ SUL ☐ SWL ☐ VUL ☐ OTHER (please specify)

TYPE OF POLICY

☐ INDIVIDUAL ☐ GROUP ☐ CONVERTED GROUP

GROUP OR INDIVIDUAL POLICY

☐ NO ☐ YES (provide details):

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

☐ NO ☐ YES (provide details and documentation of the loan):

IS OR HAS THE POLICY EVER BEEN SUBJECT TO A PREMIUM FINANCE LOAN?

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. Include the 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. Include the 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 the policy is Universal Life, you must submit minimum premium payments
  - If the policy is a Term policy, you must submit a current illustration and a conversion illustration to a permanent policy that shows minimum premium payments
  - If the policy is a Whole Life policy, you must submit a vanishing premium illustration

SIGNATURE OF FIRST INSURED DATE

SIGNATURE OF SECOND INSURED (IF APPLICABLE) DATE

SIGNATURE OF POLICY OWNER(S) DATE

LOCATION WHERE APPLICATION SIGNED BY POLICY OWNER(S):

CITY STATE

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

The purpose of this Authorization is for each Policy Owner(s) and for each Insured(s) to authorize the release, the use and the disclosure of the records and of the insurance policy information. By signing this Authorization, the Policy Owner(s) and the Insured(s) hereby authorize, agree and understand as follows:

The Policy Owner(s) and the Insured(s) authorize certain parties to provide certain information to:
A. Q Capital Strategies, LLC ("Q Capital");
B. Q Capital's authorized representatives and assignees;
C. Any life settlement broker used by the Policy Owner(s);
D. Each subsequent owner of the Policy, any party who is a potential purchaser of the Policy; and
E. To the insurance company that issued the Policy.

The parties that are authorized by the Policy Owner(s) and by the Insured(s) to release the information include:
A. The physician.
B. The medical practitioners.
C. The hospitals.
D. The clinics or any of the other medical facilities.
E. The insurance support organizations.
F. The pharmacies.
G. The government agencies.
H. The insurance companies.
I. The group policyholders.
J. The employers.
K. The benefits plan administrators.
L. And any other institutions.

The information that the Policy Owner(s) and the Insured(s) authorize to be released includes:
A. Information on the diagnosis, the treatment and the prognosis of the physical and the mental conditions of the Insured(s).
   (1) The information may include psychiatric conditions.
   (2) The information may include the results of any mental evaluations.
   (3) The information may include drug and alcohol use or abuse.
   (4) The information may include the results of any HIV tests.
   (5) The information may include the results of any AIDS tests.
B. Information on the insurance policy(ies) on which I am a Policy Owner or I am an Insured (individually or collectively, the "Policy").
   (1) This includes information on the forms, the riders and the amendments.

The Policy Owner(s) and the Insured(s) also authorize Q Capital, its authorized representatives and its assignees:
A. To use the information for the purpose of pursuing the sale of the Policy.
B. To use the information for the purpose of completing the sale of the Policy.
C. To disclose the information to each subsequent owner and any party who is a potential purchaser of the Policy from any subsequent owner.
D. To disclose the information:
   (1) To respective funding sources.
   (2) To authorized representatives.
   (3) To medical underwriters.
   (4) To insurers or contingency reinsurers of the subsequent owners and potential purchasers.

The Policy Owner(s) and the Insured(s) agree:

A. That a photocopy or a facsimile of this Authorization is as valid as the original.
B. That this Authorization is valid for twenty-four (24) months. That this is true unless there is an applicable state statute or regulation that is to the contrary. In this case, this Authorization is valid for the maximum period allowed thereunder.

The Policy Owner(s) and the Insured(s) understand that all of the medical information will be kept strictly confidential.

NAME OF FIRST INSURED	SIGNATURE	DATE
NAME OF SECOND INSURED	SIGNATURE	DATE
NAME OF POLICY OWNER(S)	SIGNATURE	DATE
NAME OF WITNESS	SIGNATURE	DATE
NAME OF WITNESS	SIGNATURE	DATE

A PHOTOCOPY OR A FACSIMILE OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

AUTHORIZATION FOR RELEASE OF INSURANCE POLICY INFORMATION

(signed by the Policy Owner(s))

With respect to the insurance policy or policies indicated below (individually and collective, the "Policy"), the Policy Owner(s) hereby authorize, instruct and agree to the following:

1. The Policy Owner(s) authorize the insurance company to release all information and forms relating to the Policy to:

   A. Q Capital Strategies, LLC ("Q Capital").
   B. Q Capital's authorized representatives or assignees.

   This information includes, but is not limited to, a verification of coverage, the illustrations and the conversions.

2. The Policy Owner(s) instruct the insurance company to:

   A. Fax all of the requested information directly to Q Capital.
   B. Forward a copy to the Policy Owner(s) where it is indicated below.

3. The Policy Owner(s) agree that a photographic copy or that a facsimile of this Authorization is valid as the original.

4. The Policy Owner(s) agree that this Authorization shall be valid for three years from the date that it is signed by each Policy Owner(s). This is true unless there is an applicable state statute or a regulation to the contrary. In this case, this Authorization is valid for the maximum period allowed thereunder.

NAME OF POLICY OWNER(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

A PHOTOCOPY OR FACSIMILE OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL

PERSONAL ACKNOWLEDGEMENT

(signed by the Policy Owner(s))

The purpose of this form is for the Policy Owner(s) to acknowledge certain information.

The Policy Owner(s) represents and warrants:

A. That all of the information in the Life Settlement Application (the "Application") is correct and it is accurate;
B. That the information may be relied upon by Q Capital Strategies, LLC ("Q Capital"), its authorized representatives and assignees, their funding sources, medical underwriters, contingency insurers and reinsurers, and purchasers of life insurance policies; and
C. That I/We will immediately notify Q Capital of any changes in the information.

The Policy Owner(s) give consent to Q Capital and to its authorized representatives or assignees, to disclose the Application and information gathered while processing the Application as necessary to:

A. Complete the sale and resale of the life insurance policy(ies) listed in the Application (individually or collectively, the "Policy"); and
B. Permit Q Capital Strategies or any subsequent policy owner(s) to obtain any of the amounts payable to them as the owner or the beneficiary of the Policy.

The Policy Owner(s) understand that some or that all of the proceeds from a Life Settlement may be taxable. I/We are encouraged to consult with an attorney or a tax advisor.

The Policy Owner(s) acknowledge:

A. That Q Capital is under no obligation to purchase the Policy.
B. That Q Capital may contact me/us regarding the information that is contained in the Application.
C. That neither Q Capital nor any of its affiliates or representatives has made any representations or provided any advice about the possible tax consequences or the tax treatment of the proceeds of a Life Settlement.

The Policy Owner(s) understand that these acknowledgements are:

A. Made to Q Capital.
B. Deemed to be made to each subsequent owner of the Policy and to anyone who is a potential purchaser of the Policy from any subsequent owner.

NAME OF POLICY OWNER(S) SIGNATURE DATE

NAME OF WITNESS SIGNATURE DATE