Q Capital Strategies

INFO@QCAPITAL.COM

LIFE SETTLEMENT APPLICATION

PERSONAL DATA

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

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

PRIMARY RESIDENCE STREET ADDRESS (NOT P.O. BOX) | TELEPHONE WITH AREA CODE

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?

OWNER of Policy No. _____ issued by _____ (Insurer Name)

NAME OF POLICY OWNER SOCIAL SECURITY OR TAX ID NUMBER

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

NAME OF MANAGER (IF LLC OWNED) - or - NAME OF MANAGING GENERAL PARTNER (IF PARTNERSHIP OWNED)

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

STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP CODE TELEPHONE WITH AREA CODE

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

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Bankrupt

For multiple Owners or multiple policies, please attach an additional page with owner and policy information as requested above.

FIRST INSURED'S MEDICAL INFORMATION – INSURED'S NAME: _____

OCCUPATION (if retired, previous occupation) SPOUSE'S MAIDEN NAME

FATHER'S NAME MOTHER'S MAIDEN NAME

NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

PHYSICIAN'S STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP CODE

NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

PHYSICIAN'S STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP CODE

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.

SECOND INSURED'S MEDICAL INFORMATION – INSURED'S NAME: _____

OCCUPATION (if retired, previous occupation) SPOUSE'S MAIDEN NAME

FATHER'S NAME MOTHER'S MAIDEN NAME

NAME OF PRIMARY PHYSICIAN TELEPHONE WITH AREA CODE

PHYSICIAN'S STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP CODE

NAME OF SPECIALIST PHYSICIAN SPECIALTY TELEPHONE WITH AREA CODE

PHYSICIAN'S STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP CODE

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.

IMPORTANT NOTICE: FOR POLICY OWNERS CONSIDERING A LIFE SETTLEMENT

Massachusetts law requires the following disclosures to be given to each policy owner at the time of an application for a life settlement:

1. The life settlement provider that is reviewing your application for a life settlement is Q Capital Strategies, LLC ("Q Capital"), whose address and telephone number are shown at the top of Page 1 of this Application form. Q Capital is not in any way affiliated with the insurance company that issued your life insurance policy, or any other life insurance company, or any life settlement broker.

2. There may be alternatives to a life settlement, including, but not limited to, accelerated benefits offered by the insurance company that issued your policy.

3. Some or all of the proceeds of a life settlement may be taxable. You are advised to seek help from a professional tax advisor.

4. The proceeds from a life settlement may be subject to the claims of creditors.

5. Receiving proceeds from a life settlement may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements. You should seek advice from the appropriate agencies.

6. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy, to be forfeited by the owner. You should seek help from a professional financial advisor.

7. A life settlement resulting in the change of ownership of your policy may, in the future, limit the Insured's ability to purchase future insurance on the Insured's life. This is because there is a limit to how much coverage insurers will issue on one person's life.

8. The policy owner has a right to terminate a life settlement contract within 15 days after the date the contract is signed by all parties. Termination of the contract is also referred to as the "rescission" of the contract.

9. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans and loan interest paid on account of the life settlement provider within the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans and loan interest to the life settlement provider.

10. All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of the insured's family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract between the owner and the life settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every 2 years.

11. The Insured may be contacted by either the life settlement provider or life settlement broker, or an authorized representative thereof, for the purpose of determining the Insured's health status or to verify the Insured's address. The Insured may not be contacted more than once every 3 months if the Insured has a life expectancy of more than 1 year, and not more than once per month if the Insured has a life expectancy of 1 year or less.

12. If you are working with a life settlement broker in this transaction, that broker represents exclusively the owner of the policy. The life settlement broker does not represent the insurer that issued the policy, Q Capital, or any other person in the life settlement transaction. The life settlement broker owes a fiduciary duty to the policy owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

13. If a life settlement broker or other person representing the owner in a life settlement will receive a fee for representing the owner, the amount and method of calculating the compensation paid, or to be paid, to such person in connection with the transaction must be disclosed to you. If you are represented by such a person and Q Capital has been instructed or has agreed to pay any compensation to that person, the amount of that compensation will be stated in a separate Transaction Disclosure Statement provided to you with your Life Settlement Contract.

14. Life settlement providers and life settlement brokers are required to print fraud warnings on application forms and life settlement contracts stating as follows: "*Any person who knowingly presents false information in a life settlement application or contract may be found guilty of a crime and may be subject to fines and confinement in prison*."

15. Proceeds from a life settlement are sent to the owner within 3 business days after the life settlement provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

    a. If you enter into a Life Settlement Contract with Q Capital, the amount payable to you will be deposited into an escrow account and will be paid to you by an independent third-party escrow agent within this 3-business-day time period.

    b. You have the right to inspect or receive copies of the relevant escrow or trust agreements or documents. When the life settlement contract form is provided to you, Q Capital Strategies, LLC will also provide you with an Escrow Agreement in which the escrow agent will be: «EscCo_FullName», «EscCo_Address», «EscCo_City», «EscCo_StateCode» «EscCo_PostalCode», telephone number «EscCo_BusPhone».

16. In addition to these disclosures, the law requires that you also receive an informational brochure or consumer advisory package in a form prescribed or approved by the office of the Massachusetts Commissioner of Insurance.

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

INSURED'S CONSENT TO RELEASE OF PROTECTED HEALTH INFORMATION

I, the undersigned Insured, agree and request the release of my protected health information ("PHI") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as follows:

1. Persons Authorized to Disclose My PHI. I authorize each doctor, hospital, pharmacy, medical practice group, laboratory, testing facility, and other health care provider (each, an "**Authorized HCP**") to disclose all of my PHI. I acknowledge that all of my PHI is necessary for the purposes described in paragraph 3. Each Authorized HCP may rely on any form of image or copy of this release.

2. Persons Authorized to Receive My PHI. I authorize each Authorized HCP to disclose my PHI to Q Capital Strategies, LLC ("**Q Capital**") and its operations, contracts, servicing and compliance department personnel, its assignees, and any other person that may at any time consider or provide financing for any purchase of, or that may own or hold any beneficial interest in a life insurance policy in which I am a named insured, or that may provide any services to the owner or holder of benefits in any such policy. My PHI may also be disclosed to any broker or agent assisting with sale of any such policy, underwriters and life expectancy providers, and the insurer that issued the policy. PHI may be release to any of their affiliates, agents, employees, and assignees for any of the purposes identified in Paragraph 3 below. Each such person is an "**Authorized Recipient**."

3. Description of PHI to Be Disclosed and Purpose of Disclosure. This release applies to any and all of my health and medical data, information, records and medical bills, even if personally identifiable. PHI may be disclosed whether or not it is protected by any federal or state privacy law or regulation. PHI relating to psychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment, and official copies of my death certificate, may also be disclosed. The purposes of release of my PHI are to allow Authorized Recipients to: (a) evaluate or underwrite my health or medical condition in connection with the possible sale of any life insurance policy in which I am a named insured; (b) effect any agreement for purchase or sale of such policy; (c) monitor or verify my health status or medical condition on behalf of any buyer, owner or beneficiary of such policy; (d) effect or perform any agreement between Q Capital and any other life settlement provider or buyer; (e) respond to any investigation or examination by any governmental officer or agency; (f) permit any funder, financing entity, or other person to finance any purchase, sale or maintenance of any interest in such policy; (g) facilitate the exercise of rights of ownership; (h) maintain and administer the policy; (i) make any claim for benefits under the policy; (j) protect the rights and interests of the policy owners and beneficiaries; or (k) purchase stop loss or reinsurance coverage related to the policy. I intend that the Authorized Recipients rely on this release in analyzing, buying, selling or taking other actions with respect to any such policy.

4. Expiration; Right to Revoke. This release expires on the earlier of the following: (a) the next business day after the date on which all claims related to the policy have been fully and finally paid and resolved, or (b) two years after the date of my death. I may revoke this release at any time except to the extent someone has taken action in reliance on it prior to receiving my written notice revoking it. To revoke this release, I must deliver written notice to the address provided by the applicable covered entity. I may not revoke this release if any law provides an insurer with the right to contest the policy or any claim under the policy.

5. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Release. I understand that no Authorized HCP or covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this release.

I understand this release is not requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations applicable to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). As a result of this release, my PHI may no longer be protected by HIPAA Privacy Regulations and there is a potential for my PHI to be re-disclosed by an Authorized Recipient. I understand that I am entitled to receive a copy of this form. I agree that this release is written in plain language. I certify that I am signing this release freely and unilaterally on the date written below, and that all contents of this release are true.

NAME OF INSURED	**SIGNATURE**	**DATE**	**DATE OF BIRTH**	**LAST 4 DIGITS OF SSN**

NAME OF WITNESS	SIGNATURE	DATE

SECOND INSURED'S CONSENT TO RELEASE OF PROTECTED HEALTH INFORMATION

I, the undersigned Insured, agree and request the release of my protected health information ("PHI") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as follows:

1. Persons Authorized to Disclose My PHI. I authorize each doctor, hospital, pharmacy, medical practice group, laboratory, testing facility, and other health care provider (each, an "**Authorized HCP**") to disclose all of my PHI. I acknowledge that all of my PHI is necessary for the purposes described in paragraph 3. Each Authorized HCP may rely on any form of image or copy of this release.

2. Persons Authorized to Receive My PHI. I authorize each Authorized HCP to disclose my PHI to Q Capital Strategies, LLC ("**Q Capital**") and its operations, contracts, servicing and compliance department personnel, its assignees, and any other person that may at any time consider or provide financing for any purchase of, or that may own or hold any beneficial interest in a life insurance policy in which I am a named insured, or that may provide any services to the owner or holder of benefits in any such policy. My PHI may also be disclosed to any broker or agent assisting with sale of any such policy, underwriters and life expectancy providers, and the insurer that issued the policy. PHI may be release to any of their affiliates, agents, employees, and assignees for any of the purposes identified in Paragraph 3 below. Each such person is an "**Authorized Recipient**."

3. Description of PHI to Be Disclosed and Purpose of Disclosure. This release applies to any and all of my health and medical data, information, records and medical bills, even if personally identifiable. PHI may be disclosed whether or not it is protected by any federal or state privacy law or regulation. PHI relating to psychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment, and official copies of my death certificate, may also be disclosed. The purposes of release of my PHI are to allow Authorized Recipients to: (a) evaluate or underwrite my health or medical condition in connection with the possible sale of any life insurance policy in which I am a named insured; (b) effect any agreement for purchase or sale of such policy; (c) monitor or verify my health status or medical condition on behalf of any buyer, owner or beneficiary of such policy; (d) effect or perform any agreement between Q Capital and any other life settlement provider or buyer; (e) respond to any investigation or examination by any governmental officer or agency; (f) permit any funder, financing entity, or other person to finance any purchase, sale or maintenance of any interest in such policy; (g) facilitate the exercise of rights of ownership; (h) maintain and administer the policy; (i) make any claim for benefits under the policy; (j) protect the rights and interests of the policy owners and beneficiaries; or (k) purchase stop loss or reinsurance coverage related to the policy. I intend that the Authorized Recipients rely on this release in analyzing, buying, selling or taking other actions with respect to any such policy.

4. Expiration; Right to Revoke. This release expires on the earlier of the following: (a) the next business day after the date on which all claims related to the policy have been fully and finally paid and resolved, or (b) two years after the date of my death. I may revoke this release at any time except to the extent someone has taken action in reliance on it prior to receiving my written notice revoking it. To revoke this release, I must deliver written notice to the address provided by the applicable covered entity. I may not revoke this release if any law provides an insurer with the right to contest the policy or any claim under the policy.

5. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Release. I understand that no Authorized HCP or covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this release.

I understand this release is not requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations applicable to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). As a result of this release, my PHI may no longer be protected by HIPAA Privacy Regulations and there is a potential for my PHI to be re-disclosed by an Authorized Recipient. I understand that I am entitled to receive a copy of this form. I agree that this release is written in plain language. I certify that I am signing this release freely and unilaterally on the date written below, and that all contents of this release are true.

NAME OF SECOND INSURED	**SIGNATURE**	**DATE**	**DATE OF BIRTH**	**LAST 4 DIGITS OF SSN**

NAME OF WITNESS	SIGNATURE	DATE

CONSENT TO RELEASE AND USE OF INSURANCE POLICY, MEDICAL AND PERSONAL INFORMATION

I/We hereby authorize the insurance company to release directly to Q Capital Strategies, LLC and/or its authorized representatives and assignees any and all information and forms in connection with the policy(ies) listed below, including, but not limited to, verification of coverage, illustrations, and any information related to any conversion or reinstatement of a policy. Upon request, you are also authorized to release copies of any and all policy forms, applications, riders, endorsements, amendments, and other attachments to any such policy, and all disclosures, questionnaires, medical examinations and financial records considered by the insurance company in underwriting the issuance and/or any reinstatement, conversion or increase in coverage of the policy(ies) listed below.

Please provide the requested information directly to Q Capital Strategies, LLC or to such representative or assignee as Q Capital Strategies, LLC may designate.

Each person signing below consents to the release of all life insurance information and records, financial records and information, and all health and medical data pertaining to the undersigned Insured(s) and/or the life insurance policy(ies) listed below by each: insurance company and insurance support organization; doctor, hospital, pharmacy, medical practice group, laboratory, testing facility, and other health care provider or medical facility; medical records bureau; government agency; policy owner, group policyholder, employer, benefits plan sponsor or administrator; or any other institution or person having possession of or control over information relating to the Insured(s) or any life insurance policy covering the life or lives of the Insured(s) (each, an "**Authorized Person**").

This Consent is intended as a request for each Authorized Person to provide all available life insurance, financial, health and medical and life insurance information to: Q Capital Strategies, LLC and its assignees; to any life settlement broker utilized by the Policy Owner(s); to each insurance company that issued any life insurance policy covering the life of the Insured(s); to underwriters and life expectancy providers as related to any such policy; to any other person or party that may at any time, now or in the future, consider or provide financing for any purchase of, or that may own or hold any beneficial interest in a life insurance policy covering the life or lives of the undersigned Insured(s), or that may provide any services to the owner or holder of benefits in any such policy; and to any affiliate, agent, employee or representative acting on behalf of any such person or party. Each such person is a "**Designated Recipient**."

Each Designated Recipient may receive, copy and otherwise use the medical, insurance and personal information received under this Consent in order to evaluate, finance or complete any life settlement contract or other lawful sale or resale of life insurance policy(ies) insuring the life or lives of the Insured(s), to administer and maintain any such policy, to make contacts for the purpose of determining the health status of the Insured(s), to respond to any investigation or examination by any governmental officer or agency having proper authority therefor, to purchase stop loss coverage, and to permit Q Capital Strategies, LLC or any subsequent owner of such a policy or holder of any beneficial interest therein to obtain any amounts payable to the owner or beneficiary of the policy. Use by any Designated Recipient shall be subject to compliance with all applicable state and federal privacy laws and regulations.

Any copy or image of this Consent shall be valid as the original. This Consent shall survive the lifetime of the undersigned Insured, or the last to survive if more than one Insured signs below, and shall expire as of the earlier of: (i) two years after the date of death of such Insured, or (ii) the maximum period permitted by law.

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

POLICY NUMBER 1	INSURANCE COMPANY
POLICY NUMBER 2	INSURANCE COMPANY

PERSONAL ACKNOWLEDGEMENT

(1) Each person signing below represents and warrants that: (a) the information contained in the above Application is accurate and complete: (b) Q Capital Strategies, LLC, and its assignees, and their representatives, funding sources, underwriters, contingency insurers and reinsurers and purchasers of life insurance policies, may rely on this information and (c) I will immediately notify Q Capital Strategies, LLC of any changes in the information.

(2) Q Capital Strategies, LLC, and its authorized representatives and assignees, are authorized to disclose the Application set forth above 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, maintaining and administering the policy(ies), and permitting Q Capital Strategies, LLC, any subsequent owner(s) of the policy(ies) listed in the Application, and any holders of beneficial interest in such policy(ies), to obtain any amounts payable to them as owner or beneficiary of the policy(ies).

(3) I acknowledge that I am 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 understand and agree that Q Capital Strategies, LLC may contact me or other regarding information contained in this Application.

(4) This Personal Acknowledgement is made to Q Capital Strategies, LLC, and deemed to be made to each subsequent owner of the Policy and holder of any beneficial interest therein, and any party who is now or at any time in the future may be a potential purchaser of the Policy or any beneficial interest in the Policy.

(5) Before signing this Personal Acknowledgement, I have received and read the disclosures set forth on pages 3 and 4 of the Life Settlement Application form. I also acknowledge that none of Q Capital Strategies, LLC, 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.

(6) I understand that if the owner(s) of the Policy reside Massachusetts, the life settlement transaction will be governed by Massachusetts law, except in certain circumstances if the policy is owned by more than one party and the owners reside in different states. If there is more than one owner in this case, each owner has completed a separate copy of the top portion of page 2 of this Application setting forth his/her/its state of residence. If any owner does not reside in Massachusetts, the owners and insured have provided written instructions regarding which state's laws will govern, which instructions shall be in compliance with the applicable laws of each owner's state of residence.

(7) In an application for insurance, the insurer may inquire whether or not the owner intends to pay premiums with financing from a lender, and may disclose to the applicant certain risks that may arise if ownership of a policy is transferred in satisfaction of a loan.

(8) Any person who knowingly presents false information in a life settlement application or contract may be found guilty of a crime and may be subject to fines and confinement in prison.

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

The following will also be needed to complete your application:

- 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