Q Capital Strategies

INFO@QCAPITALSTRATEGIES.COM

VIATICAL SETTLEMENT APPLICATION

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

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):

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

POLICYOWNER(S)

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

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

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

ADDRESS

CITY STATE ZIP

If individually owned, has Policyowner 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 Policyowner(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 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 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 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).

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 Q Capital Strategies, LLC'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 Strategies, LLC or any subsequent Policyowner(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 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 ORIGINAL

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 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 Policyowner(s), please fax the requested information to Q Capital Strategies, LLC 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, and its authorized representatives and assignees, and its funding sources and their medical underwriters and contingency reinsurers, 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 of the life insurance policy(ies) listed herein and permitting Q Capital Strategies, LLC or any subsequent Policyowner(s) 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 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.

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 POLICYOWNER(S)	SIGNATURE	DATE
NAME OF WITNESS	SIGNATURE	DATE