

VIATICAL SETTLEMENT APPLICATION

(Any person who knowingly presents false information in an application for insurance or viatical settlement contract or viatical settlement purchase agreement may be guilty of a crime and prosecuted under state law.)

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 STA	ATE ZIP		
REASON FOR SALE			
FIRST INSURED MEDICAL CONDITION (BE	RIEF DESCRIPTION)		
SECOND INSURED MEDICAL CONDITION	(BRIEF DESCRIPTION)		
LIFE INSURANCE POLICY	INFORMATION		
INSURANCE COMPANY	POLICY NUMBER	ISSUE D	ATE
FACE AMOUNT	ACCOUNT VALUE	CASH SU	URRENDER VALUE
ANNUAL PREMIUM PAYMENT	NEXT PREMIUM DUE DATE	TOTAL	POLICY LOAN
LAST PREMIUM PAID DATE	AMOUNT PAID		
ANNUAL SEMI-ANI PREMIUM MODE	NUAL QUARTERLY	☐ MON	ГНГА
TERM UL WL	SUL SWL VUL	□ОТНЕ	ER (please specify)
☐ INDIVIDUAL ☐ GROUP GROUP OR INDIVIDUAL POLICY	☐ CONVERTED GRO	OUP	
NO YES (provide detailed that the ownership of the policy ch			
_	ails and documentation of the loan):		
119 West 72 ND Street ·Suiti	E 340 · NEW YORK, NY 10023 · (21)	2) 418-3270	·FAX (212) 980-6654

Q CAPITAL STRATEGIES, LLC	VIATICAL SETTLEMENT APPLICATION · PAGE 2
POLICY OWNER(S)	
NAME OF POLICY OWNER(S)	SOCIAL SECURITY OR TAX ID NUMBER
NAME OF PRESIDENT (IF CORPORATE OWN	ED) 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 Ow	oner ever been? (check all that apply)
☐ Married ☐ Divorced	☐ Legally Separated ☐ Widowed ☐ Bankrupt
and life insurance policy information MEDICAL INFORMATION FIRST INSURED	nitted, please attach an additional page including Policy Owner(s) as requested above.
NAME OF PRIMARY PHYSICIAN	TELEPHONE WITH AREA CODE
ADDRESS	
СІТҮ	STATE ZIP
NAME OF SPECIALIST PHYSICIAN	SPECIALTY TELEPHONE WITH AREA CODE
ADDRESS	
CITY	STATE ZIP

Q CAPITAL STRATEGIES, LLC	VIATIO	CAL SETTLEMENT APPLICATION · PAGE 3
SECOND INSURED		
NAME OF PRIMARY PHYSICIAN	TELEPHONI	E 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 hadditional page including full name of code.		
 The following will be needed to obta Copy of the insurance policy and cur In-force illustrations showing zero care If Universal Life policy, submit If Term policy, submit a current showing minimum premium pay If Whole Life policy, submit a v 	rrent statement of values ash value at maturity: minimum premium payme illustration and a conversionments	on illustration to a permanent policy

DATE

SIGNATURE OF FIRST INSURED

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION (signed by the Insured(s) and Policy Owner(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 to Q Capital Strategies, LLC and/or its authorized representatives or assignees or to any viatical settlement broker utilized by the Policy Owner(s) 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) 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 or 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) 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 twenty-four (24) months, 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)	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))

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	
ADDRESS	SOC	IAL 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 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
NAME OF WITNESS	SIGNATURE	DATE