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 felony 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 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 including 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 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 POLICY OWNER(S) DATE

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, to any viatical settlement broker utilized by the Policy Owner(s), and, if the policy being viaticated has been in effect for less than five (5) years, to the insurance company that issued the life insurance policy covering the life of the Insured(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 thirty (30) 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 thirty (30) 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.

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

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. I also acknowledge that I have received the information brochure describing the process of viatical settlements.

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