



PO Box 419
 Northport, NY 11768
 Phone: 631-239-6655
 Fax: 631-239-6657
www.go2veris.com

Key Information to evaluate a potential Viatical Settlement:

Prospect Name(s) _____

Agent Name _____

Agent Address _____

Agent Phone Number _____ Agent E-mail Address _____

Please check off that you are providing all of the following:

	Completed Pre-Qualification Worksheet (VSP-008)
	Completed Viatical Settlement Appraisal Form (VSP-004)
	<ul style="list-style-type: none"> • Medical records (as current as possible) going back for five years
	<ul style="list-style-type: none"> • A list of all physicians consulted during the past five years (name, address and telephone numbers) and a summary of the insured’s medical history
	<ul style="list-style-type: none"> • A signed copy of the Terms and Conditions
	A signed copy of the “Authorization for the Disclosure of Health Information” (VSP-003)
	A signed copy of the “Authorization for the Release of Policy Information” (VSP-007)
	A signed copy of the “Broker of Record” letter
	Verification of Coverage (VOC) (VSP-022). This form is a separate form, to be sent to insurance carrier for them to complete and send back to Veris Settlement Partners.
	A clear copy of the Driver’s License
	An in-force illustration showing level death benefit to maturity (at minimum level premium and zero cash value at maturity)
	A copy of the life insurance policy and application
	If the policyowner is a trust, a copy of the trust agreement
	A copy of the most recent annual statement for the policy

Once an offer has been made and accepted all of the information requested above (plus any additional information the Provider requests) must be provided before a closing document can be prepared.



PO Box 419
 Northport, NY 11768
 Phone: 631-239-6655
 Fax: 631-239-6657
www.go2veris.com

Viatical Settlement Pre-Qualification Worksheet

Prospect Name(s) _____ **Score** _____

Please rate each category and add the points for a total score. Compare the score with the table below for a viatical settlement probability. (If more than one policy is being submitted, please complete this worksheet for all policies.)

- Policy face amount must be at least \$100,000
- Carrier is rated A- or better
- Insured is US citizen

Client age and sex:

- 0 Points** Male age 70 or less/Female age 73 or less
- 1 Point** Male age 71-74/Female age 74-77
- 2 Points** Male age 75-78/Female age 78-81
- 3 Points** Male age 79-83/Female age 82-86
- 4 Points** Male age 84+/Female age 87+

Medical conditions:

- 1 Point** No changes in health since policy issue
- 2 Points** Minimal changes in health since policy issue
- 3 Points** Moderate changes in health since policy issue
- 4 Points** Major changes in health since policy issue

Policy type:

- 1 Point** Joint Survivorship UL with two living insureds or Whole Life
- 2 Points** Term life (still convertible)
- 3 Points** Guaranteed Universal Life
- 4 Points** Current Assumption Universal Life or Joint Survivorship UL with one deceased

Current Cash Surrender Value:

- 1 Point** 30%+ of the Death Benefit
- 2 Points** 20%-30% of the Death Benefit
- 3 Points** 10%-20% of the Death Benefit
- 4 Points** 0%-10% of the Death Benefit

Outstanding loans:

- 1 Point** 30%+ of the Death Benefit
- 2 Points** 20%-30% of the Death Benefit
- 3 Points** 10%-20% of the Death Benefit
- 4 Points** 0%-10% of the Death Benefit

Current premiums to maturity:

- 1 Point** 4%+ of the Death Benefit
- 2 Points** 3%-4% of the Death Benefit
- 3 Points** 2%-3% of the Death Benefit
- 4 Points** 1%-2% of the Death Benefit

Contestability/insurable interest:

- 1 Point** Premium financed: Non-recourse
- 2 Points** Premium financed: Recourse
- 3 Points** Not premium financed, 24-30 months from issue
- 4 Points** Not premium financed, over 30 months from issue

Final Score	Viatical Settlement Probability
10 points or less	Highly unlikely
11-16 points	Unlikely—please call Veris to discuss
17-22 points	Average—contact client to complete submission package
23 points or more	Highly likely—contact client to complete submission package



PO Box 419
 Northport, NY 11768
 Phone: 631-239-6655
 Fax: 631-239-6657
www.go2veris.com

Viatical Settlement Appraisal Form

Primary Insured's Name Date of Birth Sex Marital Status Social Security #

Second Insured's Name Date of Birth Sex Marital Status Social Security #

 Primary Address City, State, Zip

 Daytime Phone Number Evening Phone Number

Do you have a residence in another state? Yes No If yes, please provide along with how many months of the year you live there:

 Address City, State, Zip Months of year

Life Insurance Policy Information-Policy #1

Insurance Company	Policy Number	Date of Issue	Policy Date
Face Amount \$	Existing Policy Loan \$	Current Annual Premium \$	
Current Cash Surrender Value \$	Policy Type (circle one): Universal Life Whole Life Variable Life Term Survivor* Group Other-		
Policyowner	Policyowner's Social Security # or Tax ID #	Drivers Lic. # (State)	
Policyowner's Address			
City, State	Zip	Phone	
Beneficiary Name and Address (1)			
(2)			
*If Survivor, are both insureds living? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, name of insured who is deceased:			

***For additional owners or beneficiaries, please attach additional sheet as necessary.
 If policyowner is trust, please list trustee(s), addresses & phone numbers.***

Trustee _____

Address _____

(Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)

Life Insurance Policy Information-Policy #2

Insurance Company	Policy Number	Date of Issue	Policy Date
Face Amount \$	Existing Policy Loan \$	Current Annual Premium \$	
Current Cash Surrender Value \$	Policy Type (circle one): Universal Life Whole Life Variable Life Term Survivor* Group Other-		
Policyowner	Policyowner's Social Security # or Tax ID #	Drivers Lic. # (State)	
Policyowner's Address			
City, State	Zip	Phone	
Beneficiary Name and Address (1)			
(2)			
*If Survivor, are both insureds living? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, name of insured who is deceased:			

*For additional owners, please attach additional sheet as necessary.
 If policyowner is trust, please list trustee(s), addresses & phone numbers.*

Trustee _____

Address _____
 (Use additional sheet as necessary for additional trustees and please attach copy of trust document and, if necessary, any amendments hereto.)

	Policy #1			Policy #2		
Has the policyowner ever declared bankruptcy?	Yes	or	No	Yes	or	No
Has policyowner been divorced?	Yes	or	No	Yes	or	No
Is the policyowner currently a defendant in a legal proceeding?	Yes	or	No	Yes	or	No
Was the policy financed?	Yes	or	No	Yes	or	No
If so, by which financing company?	_____			_____		

Primary Insured Medical Information		
<i>Brief Description of Insured Medical History and Condition(s)</i>		
Primary Physician Name	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
<hr/>		

For additional specialists, please attach additional sheet as necessary.

Hospital Information

If hospitalized in the past five years, please fill in the following:

Hospital (include city and state)	Condition	Length of stay
1		
2		
3		
4		

Primary Insured Medical Information

Height: _____ Weight: _____

Have you ever had any of the following?

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Memory Loss |

Please provide any additional details on the above conditions: (Attach a separate sheet if more space is needed)

Current prescribed medications _____

Do you exercise, and if so, how much? _____

Places travelled in past five years (both business and personal) _____

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco?

If so, please describe: _____

Primary Insured Family History

Have family members had:	Father	Mother	Siblings		If Living Age	If Deceased Age and Cause of Death
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother		
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brother(s)		
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sister(s)		

Important Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison.

Second Insured Medical Information		
<i>Brief Description of Insured Medical History and Condition(s)</i>		
Primary Physician Name	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		
Insured's Specialist and Specialty	Address	
City, State	Zip	Phone
Date and reason last seen		

For additional specialists, please attach additional sheet as necessary.

Hospital Information

If hospitalized in the past five years, please fill in the following:

Hospital (include city and state)	Condition	Length of stay
1		
2		
3		
4		

Second Insured Medical Information

Height: _____ Weight: _____

Have you ever had any of the following?

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Memory Loss |

Please provide any additional details on the above conditions: (Attach a separate sheet if more space is needed)

Current prescribed medications _____

Do you exercise, and if so, how much? _____

Places travelled in past five years (both business and personal) _____

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco?
 If so, please describe: _____

Second Insured Family History

Have family members had:	Father	Mother	Siblings		If Living Age	If Deceased Age and Cause of Death
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Father		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mother		
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brother(s)		
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sister(s)		

Important Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison.



Terms and Conditions:

Veris Settlement Partners, Inc. is in the business of arranging life settlement transactions, and is licensed as a life insurance agent and/or Life Settlement/Viatical Broker as required in the various states in which we conduct business. Once we accept your application, we bear all the expenses associated with the transaction, including but not limited to obtaining medical records and life expectancy studies, policy analysis, modeling, and preparing and maintaining a complete file for submission to the marketplace and for regulatory compliance purposes. We then make a diligent effort to stimulate competing bids in attempt to provide the highest possible value for each policy offered into the secondary market. Veris Settlement Partners, Inc. is acting solely on your behalf in this transaction; we do not in any way represent the purchaser of the policy other than in soliciting and delivering offers on your behalf, and assisting in the closing process once an offer is accepted by you.

Veris Settlement Partners, Inc. is compensated for its services on a “success” basis. Veris Settlement Partners, Inc. takes a “value-added” and fully transparent approach to compensation. Upon successful completion of a transaction, Veris Settlement Partners, Inc.’s fee is the greater of 10% of the net gain to the seller (which is the difference between the cash surrender value of the contract and the gross proceeds from the transaction) or 1% of the Death Benefit.

Unless an acceptable offer is obtained by us and accepted by you no fees or commissions are payable. If you do accept an offer presented by Veris Settlement Partners, Inc., we will receive a portion of the gross purchase price in compensation for services rendered. Total compensation to all parties shall not in any event exceed the lesser of 8% of the face amount of the policy or 30% of the gross purchase offer. If you have been referred to us by your insurance agent or other representative, they may be entitled to share in such compensation.

I hereby accept these terms and conditions and authorize and appoint Veris Settlement Partners, Inc. to act exclusively on my/our behalf for the purposes of securing a life settlement on the policies described within this application. This appointment shall be valid for 120 days unless notice of termination is given to Veris Settlement Partners, Inc. in writing. I also acknowledge that I have received the Required Notice (form VSP-021) included with this application.

 Signature of Owner 1

 Signature of Owner 2

 Printed Name of Owner 1

 Date

 Printed Name of Owner 2

 Date

 Signature of Insured 1

 Signature of Insured 2

 Printed Name of Insured 1

 Date

 Printed Name of Insured 2

 Date

It is your responsibility to continue paying premiums until the life settlement transaction is completed. The policy cannot be sold if it is in pending lapse or grace; therefore, the premiums must be current.



PO Box 419
Northport, NY 11768
Phone: 631-239-6655
Fax: 631-239-6657
www.go2veris.com

Authorization for Disclosure of Protected Health Information (HIPAA Compliant)

For Viatical Settlement

The undersigned insured(s) (hereafter referred to as “I”, “me”, or “my”), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an “HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each authorized HCP to rely upon photostatic or facsimile copy or other reproduction of this authorization.
2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each authorized HCP to disclose my PHI under this authorization to Veris Settlement Partners, Inc., American Viatical Services, Inc., Fasano Associates, Inc., Examination Management Services, Inc., 21st Services, including any of their affiliates, agents, subsidiaries, corporate parents, independent contractors, authorized representatives, service providers, life settlement providers and the officers, directors, and employees of each (each an “Authorized Recipient”). I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to an authorized recipient, including transmission via web posting to a secure website.
3. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information, records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purpose of allowing authorized recipients (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, certificate of life insurance, under which my life is insured to the authorized recipient and (2) to monitor, track, and verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacement therefore, that Veris Settlement Partners, Inc. brokers.
4. Expiration: This authorization shall remain valid until one (1) year after the date of my death.
5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any authorized HCP by notifying such authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such authorized HCP; provided, that any revocation of this authorization shall not apply to the extent that the authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.



6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provisions of Authorization:
No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy regulations"). I further understand that, as a result of this authorization, there is potential for my PHI that is disclosed by an authorized HCP to an authorized recipient to be subject to redisclosure by an authorized recipient and my PHI that is disclosed to such authorized recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received a copy of this signed authorization for future reference.

Signature of Insured 1

Printed Name of Insured 1

Date

Signature of Insured 2

Printed Name of Insured 2

Date

Signature of Witness

Printed Name of Witness

Date



Veris Settlement Partners
PO Box 419
Northport, NY 11768
Phone: 631-239-6655
Fax: 631-239-6657
www.go2veris.com

Authorization to Release Information

The undersigned is the owner of, or named insured under, one or more life insurance policies identified below. In order to effect a viatical settlement contract between the owner and a viatical settlement provider, or to effectuate the sale or transfer of a viatical settlement contract or a settled policy, or interest therein, the undersigned each hereby consent to the release of information to the authorized recipients specified herein.

Information Authorized to be Released: Any information (1) concerning or related to the identity of the owner of, or the named insured under, the life insurance policies identified below, (2) that there is a reasonable basis to believe could be used to identify the insured or owner, and (3) concerning or related to the owner's or insured's financial or medical information may be released to the authorized recipients (as defined below). Such information may include (but is not limited to): the name, address, telephone numbers, social security number, tax records, medical records, credit information and other non-public personal information of or related to the insured or the owner, or representative thereof; and the related insurance policy number(s).

Authorized Recipients of Information: Information authorized to be released hereunder may be released to (1) any viatical settlement broker, (2) any viatical settlement provider (a "viatical settlement provider"), (3) any person who may seek to purchase from such viatical settlement provider any life insurance policy insuring the below identified insured's life or other insurance product owned by the below identified owner, (4) any financing entity of a viatical settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (5) any service provider, including, but not limited to, any life expectancy underwriter, escrow agent or post-purchase policy servicer, (6) any life insurance or annuity company that has issued a life insurance policy insuring the below identified insured's life, and (7) any of the respective affiliates, directors, officers, employees, agents, representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (1) through (6), inclusive (each, an "authorized recipient"). Each authorized recipient in receipt of information authorized to be released by this authorization may share any such information with any other authorized recipient as if such other authorized recipient had received such information directly from the undersigned.

The undersigned each certify that this authorization has been made freely, voluntarily and without coercion and that the information shown below is accurate and complete to the best of the undersigned's knowledge. The undersigned understands that any revocation of this authorization will not apply to information that has already been released in response to this authorization. Rediscovery of the undersigned's information by those receiving the above authorized information may be accomplished without the undersigned's further written authorization and may no longer be protected. The undersigned releases any authorized recipient from any and all liability for actual or alleged damages to the undersigned as a result of good faith compliance with this authorization. This authorization is valid for the duration of the life insurance policy(-ies) specified below, provided that this authorization shall be of no force or further effect if a life settlement contract is not effected. The undersigned each acknowledge receipt of a copy of this authorization.

A copy of this authorization may be accepted as an original. This authorization may be sent via facsimile transmission.



Insurance Company Policy Number

Insurance Company Policy Number

Insurance Company Policy Number

Policyowner Information

Policyowner Name

Signer's Printed Name Signature Title (if applicable) Date

Street Address

City State Zip

Witness Printed Name Witness Signature Date

Insured Information

Insured Printed Name Insured Signature Date

Street Address

City State Zip

Witness Printed Name Witness Signature Date



Veris Settlement Partners
 PO Box 419
 Northport, NY 11768
 Phone: 631-239-6655
 Fax: 631-239-6657
www.go2veris.com

Illinois Owner and Insured Disclosures

IMPORTANT-READ THIS DISCLOSURE FORM AND THE ENCLOSED VIATICAL SETTLEMENT INFORMATION BROCHURE BEFORE SIGNING A VIATICAL SETTLEMENT CONTRACT.

You should carefully read the following information and seek financial, insurance, tax and other advice where appropriate.

1. If a viator enters into a viatical settlement contract, then the beneficiaries of the life insurance policy lose the life insurance policy's benefits, equity, and protection. In addition, by entering into this viatical settlement contract, the insured may not qualify for another life insurance policy or may be required to pay substantially higher premiums.
2. That there are possible alternatives to viatical settlement contracts including any accelerated death benefits or policy loans offered under the viator's life insurance policy.
3. That a viatical settlement broker represents only the viator and not the insurer or the viatical settlement provider and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator.
4. That some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance may be sought from a professional tax advisor.
5. That proceeds of the viatical settlement contract may be subject to the claims of creditors.
6. That receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements and advice should be obtained from the appropriate government agencies.
7. That the viator has the right to rescind a viatical settlement contract before the earlier of 30 calendar days after the date upon which the viatical settlement contract is executed by all parties or 15 calendar days after the viatical settlement proceeds have been paid to the viator. Rescission, if exercised by the viator, is effective only if both notice of the rescission is given and the viator repays all proceeds and any premiums, loans, and loan interest paid on the account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract is deemed to have been rescinded, subject to repayment by the viator or the viator's estate to the viatical settlement provider of all viatical settlement proceeds and any premiums, loans, and loan interest paid on the account of the viatical settlement within 60 days after the insured's death.
8. That funds must be sent to the viator within 3 business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy has been transferred and the beneficiary has been designated.
9. That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the viator. Assistance should be sought from a financial adviser.

Policyowner's initials _____

Insured's initials _____



10. A viatical settlement provider or viatical settlement broker may ask the insured for medical, financial, and personal information. All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about an insured, including the insured’s identity or the identity of the insured’s family members, the insured’s spouse or the insured’s significant other, may be disclosed as necessary to effect the viatical settlement between the viator and the viatical 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. That, following execution of a viatical settlement contract, the insured may be contacted for the purpose of determining the insured’s health status and to confirm the insured’s residential or business street address and telephone number, or for other purposes permitted by law. This contact is limited to once every 3 months if the insured has a life expectancy of more than one year, and no more than once each month if the insured has a life expectancy of one year or less. All such contacts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement, or by the authorized representative of a duly licensed viatical settlement provider.
12. If the policy to be viaticated is group coverage, the insured is advised to check with the manager of the group about whether permission is required to sell the policy or other conditions.
13. Entering into a viatical settlement contract will result in investors having a financial interest in the insured’s death.

A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

1. The name, business address, and telephone number of the viatical settlement broker;
2. A full, complete, and accurate description of all offers, counteroffers, acceptances, and rejections relating to the proposed viatical settlement contract;
3. Any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts;
4. The amount and method of calculating the broker’s compensation, which term “compensation” includes anything of value paid or given to a proposed settlement broker in connection with the proposed viatical settlement contract;
5. If any portion of the viatical settlement broker’s compensation, the broker shall disclose the total amount of the viatical settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker’s compensation; and
6. The name of the legal owner and beneficiary of the insurance policy after the policy is sold pursuant to the viatical settlement contract and whether legal ownership of the policy and the beneficiary’s right to collect benefits upon the viator’s death can be sold.

Policyowner’s initials _____

Insured’s initials _____



Important Consumer Notices

By entering into a viatical settlement contract:

1. You are making a complex financial decision that may or may not be in your or your family's financial best interest. Seek independent advice from financial planning experts and responsible government agencies.
2. You may not be able to purchase another life insurance policy.
3. You could lose Medicaid and other valuable government benefits.
4. You will receive proceeds that may be subject to federal and state taxes and to the claims of creditors.
5. You have sold your life insurance policy to strangers who have a financial interest in the life and death of the person whose life is insured by the policy.
6. You or your residence may be contacted on a regular basis to determine if you have died or if your health status has deteriorated.

Policyowner's initials _____

Insured's initials _____



Illinois Owner and Insured Disclosures Signature Page

LIFE INSURANCE POLICYOWNER'S AND INSURED'S ACKNOWLEDGMENT: I/We have read and fully understand the Owner and Insured disclosures and acknowledge with my signatures below. A copy of these required written disclosures have been received by the Owner and Insured. Further, I/We have received a consumer information booklet in a form prescribed by the Superintendent, or other similar material, subject to the approval of the Superintendent.

Policyowner 1

Printed Name	Signature	Date
--------------	-----------	------

Policyowner 2 (if applicable)

Printed Name	Signature	Date
--------------	-----------	------

Insured

Printed Name	Signature	Date
--------------	-----------	------

Viatical Settlement Broker

Printed Name	Signature	Date
--------------	-----------	------

Viatical Settlement Provider

(to be signed after submission by the Viatical Settlement Broker with seller and insured signatures)

Printed Name	Signature	Date
--------------	-----------	------



Veris Settlement Partners
 PO Box 419
 Northport, NY 11768
 Phone: 631-239-6655
 Fax: 631-239-6657
www.go2veris.com

Viatical Settlement Broker Compensation, Affiliation and Gross Offer to Net Proceeds Disclosure

Seller's Name _____

Insured's Name _____

Policy Number _____

Policy Face Amount \$ _____

Total Gross Offer From Viatical Settlement Provider
 Before Deducting Compensation/Adjustments \$ _____

Less Compensation and Other Adjustments
 Paid From the Proceeds

<u>Name</u>	<u>Compensation/Adjustments</u>
Viatical Settlement Broker	\$ _____
Other Compensation/Adjustment	\$ _____
Total Compensation/Adjustment Paid	\$ _____
Net Amount Paid to You	\$ _____

Policy Owner's Initials _____



Viatical Settlement Broker Compensation, Affiliation and Gross Offer to Net Proceeds Disclosure

State any affiliations or contractual arrangements with any viatical settlement provider, other viatical settlement broker, any viatical settlement transaction intermediary or any financing entity involved in this transaction: (If there are none, then write "None")

Policy Owner's Initials_____



Vital Settlement Broker Compensation, Affiliation and Gross Offer to Net Proceeds Disclosure

Seller's Name _____

Insured's Name _____

Insurer _____

Policy Number _____

Policy Face Amount: _____

Cash Surrender Value: _____

Offers, Counteroffers, Acceptances and Rejections

	Provider's Name	Provider's Name	Provider's Name	Provider's Name	Provider's Name
Gross Offer	\$	\$	\$	\$	\$
Counteroffers					
Counteroffers					
Acceptances					
Rejections					

Policy Owner's Initials _____



Acknowledgement and Signature Page

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGEMENT: I have read and received a copy of the disclosure form entitled "Viatical Settlement Broker Compensation, Affiliation and Gross Offer to Net Proceeds," including the section entitled "Viatical Settlement Broker Viatical Settlement Offers, Counteroffers, Acceptances and Rejections," to which this acknowledgement is attached.

Owner

Life Settlement Broker

Signature of Policy Owner

Signature of Viatical Settlement Broker

Printed Name of Policy Owner

Printed Name of Viatical Settlement Broker

Dated

Dated

[If multiple owners, all owners must sign.]



PO Box 419
Northport, NY 11768
Phone: 631-239-6655
Fax: 631-239-6657
www.go2veris.com

Authorization for Release of Policy Information

I hereby request and authorize _____, the insurer of life insurance Policy Number _____ and/or Certificate Number _____ owned by _____ [Insert name of policyowners(s)], and insuring the life of _____ [Insert name of Insured(s)], to release to Veris Settlement Partners, Inc. and/or its authorized agents, successors, assignees and affiliates, and their authorized representatives, any and all information concerning the above policy (including any conversion thereof or replacement therefore). This includes, but is not limited to, complete copy of all policies and policy forms, master policies and certificates for any group policies, all applications, policy illustrations, verification of coverage forms, change of beneficiary forms, and collateral and/or absolute assignment forms, as well as other information reflecting ownership and benefits payable under the policy, liens and assignments, premium waivers, and all provisions of the policy related to the foregoing.

This Authorization shall be effective from the date of signature until expiration of two (2) years following the death of the Insured(s). However, if any governing law or regulation limits this authorization to a shorter period of time, then Release shall remain in force for the maximum period of time allowed by law.

I agree that any copy or facsimile of this Authorization shall be valid as the original.

This Authorization may be signed in counterparts if required to complete execution. This Authorization is effective as to each insured and each policyowner and is not conditioned upon signature by other insureds or policyowners. It shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.

Signature of Policyowner

Signature of Policyowner

Printed Name

Date

Printed Name

Date

Required Notice

Important Information You Need to Know Before Entering Into a Viatical Settlement

What are viatical settlements?

A viatical settlement is the sale of a life insurance policy or certificate (hereafter referred to as policy) issued on the life of a person for a dollar amount that is less than the policy's face value. The person who is insured under the policy is called a viatical settlor. This person may or may not be the owner of the policy. Only the owner of the policy has the right to sell the policy. If you do not own the policy, the owner cannot sell the policy without your consent. The entity that buys the policy is called a life settlement provider (hereafter referred to as provider) and must have a registration from your state's Department of Insurance. Additionally, there are persons called brokers or provider representatives, who help with the sale of the policy. The provider representative or broker must also have a registration from your state's Department of Insurance.

A viatical settlement offers you the opportunity to receive a portion of your policy's death benefit while you are still alive.

How do viatical settlements work?

Most providers, provider representatives, or brokers will ask you to complete an application and medical release forms so that they can gather information from your life insurance company and your doctors. All information gathered must be kept confidential and cannot be given to anyone without your written approval. If you qualify, the provider will make you an offer for your policy. The amount offered for your policy will be based on facts such as how long you are expected to live, the amount you pay for premiums, the rating of your insurance company, and your policy's provisions (e.g., a waiver of premium). If you accept the offer, you will be asked to sign a viatical settlement contract.

Do I have to sell all of my policy?

No. You can sell all of your policy or you can sell only a part of your policy. If you sell only a part, you will be required to assign or transfer only the part being sold. If you sell the entire policy, the provider will become the new owner of the policy.

Is there a difference between a broker and a provider representative?

Yes. Although both a broker and a provider representative will help you with the sale of your policy, there are important differences between them. A broker works for you. A broker will check with several providers to find the best offer for you. A provider representative works for a provider. A

provider representative will only check with the provider that he or she works with to get you their offer. If you use someone to help with the sale of your policy, you may want to ask whether they are a broker or a provider representative.

Is the provider, provider representative, or broker required to keep my information confidential?

Yes, any financial, medical, or personal information obtained by a provider, provider representative, or broker about you, including your family members, a spouse, or a significant other, may not be shared with anyone unless you have given written approval that the information may be shared. Any written approval for the sharing of this information must show who may get the information and why it will be released.

If I enter a viatical settlement contract, when will I get my money and who from?

The answer to this question depends on how the provider runs its business. Some providers use an escrow agent or trustee to handle the money that will be paid to you. If an escrow agent or trustee is used, the escrow agent or trustee will send you the money within three business days of the date the insurance company confirms to the provider that the transfer of ownership has been completed. If an escrow agent or trustee is not used, the provider will send you the money within three business days from the date you signed both the contract and the papers needed to transfer or assign your policy to them.

What if I change my mind?

If you change your mind about selling your policy, most states have a rescission period after you receive the money from the provider. The guidelines for any rescission period will be explained in detail in the Viatical Settlement Purchase and Sale Agreement, which can vary on a state to state basis.

What if I die shortly after selling my policy?

After you receive the money from the provider, if you die at any time during any rescission period (which would be explained in detail in the Viatical Settlement Purchase and Sale Agreement), the settlement contract will automatically cancel. The provider will pay the owner of your policy or beneficiaries designated by the owner in the viatical settlement contract any proceeds it receives from your policy, minus any money it already paid for the purchase of your policy and any premiums it paid to the insurance company to keep your policy current. The insurance company or the provider should refund any unearned premiums paid.

What happens after I get my money?

After the provider has paid the owner for the sale of the policy, they may begin calling to check on the health status of the viatical settlor.

What if I don't want to be contacted about my health status?

If you do not want to be contacted about your health status, you may appoint an adult person or persons to be contacted on your behalf. That person must be in regular contact with you and you must give the provider their name, address and phone number. Once you give the provider this information, they may not contact you unless they have tried and have not been able to reach your contact person for more than 30 days. If you need to, you can change your contact person at any time by sending a written notice to the provider.

How will I know who will be calling me or my contact person about my health status and how often can they call?

The provider must give you the name, address, and phone number of the person who will be contacting you or your contact person(s) about your health status.

If your life is expected to end in one year or less, contacts to check on your health status are limited to once every 30 days. If you are expected to live for more than one year, contact is limited to once every three months.

Will the provider be calling my doctor to check on my health status?

Some providers will use your signed medical release form to check with your doctor for updates on your health status. The medical release form tells your doctor that you want your doctor to give your medical information to the provider, their broker, or provider representative. If you decide you do not want the provider to contact your doctor, you have the right to withdraw your medical consent in accordance with law.

Does anyone make money or commissions from the sale of my policy?

You have the right to ask for and receive the names of all the people who have or will receive some type of payment from the sale of your policy, along with the amount and terms of the payment. You may ask for this information at any time.

How will I know if my policy includes extra coverages like accidental death, future increases in the death benefit, or covers other family members? Do these affect my settlement?

Some policies contain extra coverages. You may want to contact your insurance company or agent to see if your policy contains a provision or rider providing extra coverages.

If your policy includes a benefit for accidental death, the additional death benefit may not be included as part of your settlement. The additional death benefit will remain payable to your beneficiaries or your estate.

If your policy provides future increases in the death benefit, you may want to ask how much the provider is paying you for the purchase of this benefit.

If your policy is a joint policy, or provides coverage on the lives of other family members or anyone other than yourself, there may be a possible loss of coverage.

Are there other options available besides selling my policy?

Your insurance company may offer options, such as accelerated death benefits, loans, and surrender of the policy for its cash value. Before entering into a viatical settlement, you should contact your insurance company or agent to see what options are available.

What other things should I know about a viatical settlement contract?

Some things that may be affected if you enter a viatical settlement are:

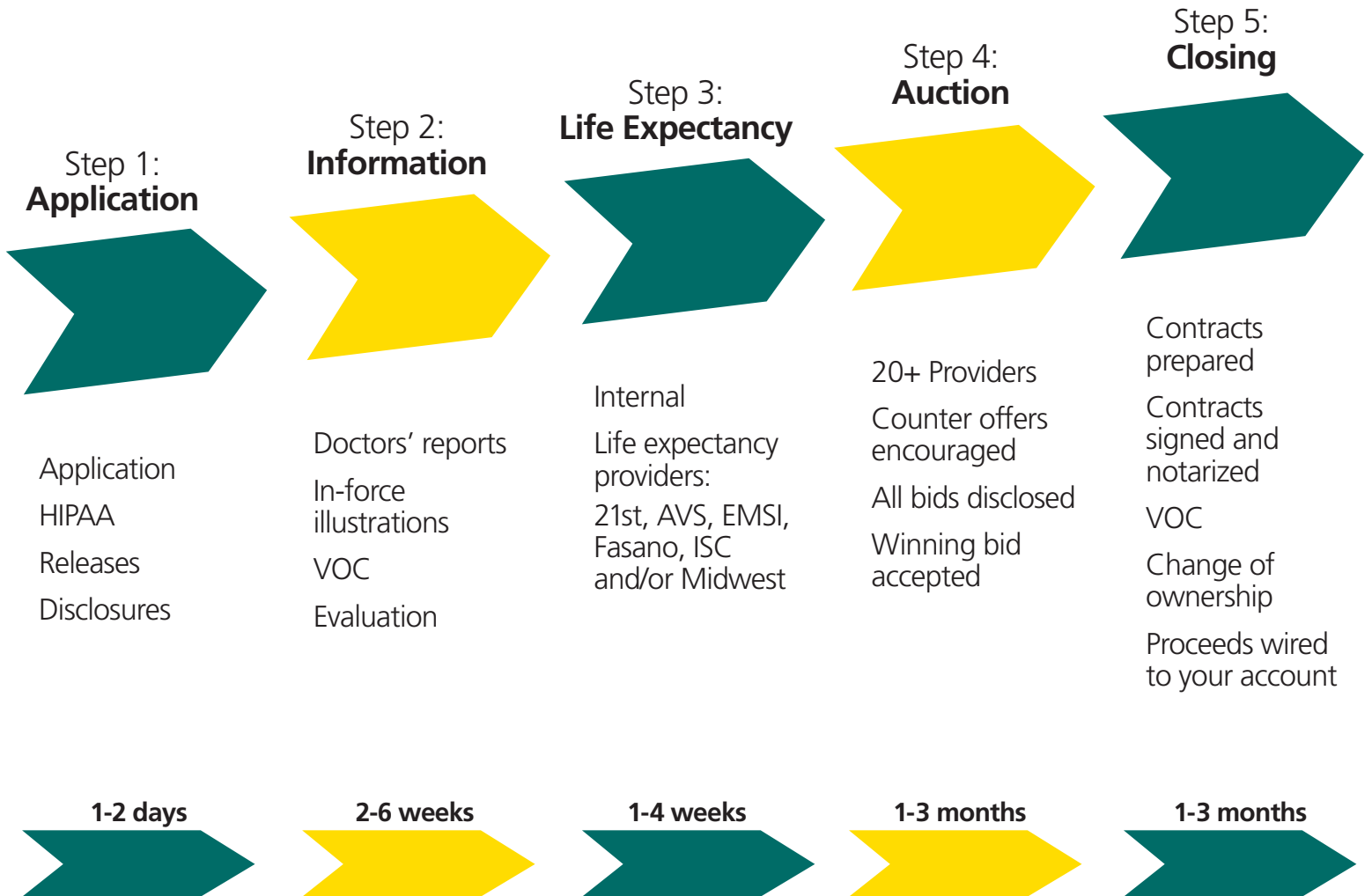
- there may be a loss of life insurance coverage on your spouse or other family members, if the policy (or any riders attached to it) covers their lives;
- the amount of premiums you pay;
- policy cash values or dividends, if provided for in the policy;
- a loss of other rights or benefits, including conversion rights and waiver of premium benefits that may exist under your policy;
- you may incur tax consequences;
- your ability to receive supplemental social security income, public assistance, and public medical services including Medicaid; and
- the money you receive for your viatical settlement could be taken away from you by creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court.

Because of the above, you should contact an attorney, accountant, estate planner, financial planning advisor, tax advisor, social services agency, your insurance company, or agent, as applicable, to find out what effect selling your policy will have on you.

What if I have a complaint?

You may file a complaint with the Department of Insurance in your state.

Viatical Settlement Process



VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO: _____ **NAIC #** _____
 Name of Insurance Company

POLICY NUMBER: _____

SUBMITTED FROM: _____
 Name of Life Settlement Producer/Provider

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____ **TITLE:** _____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE LIFE SETTLEMENT PROVIDER/PRODUCER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Life Settlement Producer/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or social security number	*	
Insured's name	*	
Insured's date of birth	*	
Second insured's name (if applicable)	*	
Second insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the life settlement producer/provider.

Signature of policy owner _____ **Date signed**

IS THE POLICY IN FORCE? _____ **YES** _____ **NO**
 IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE LIFE SETTLEMENT PRODUCER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

* _____ **TERM** _____ **WHOLE LIFE** _____ **UNIVERSAL LIFE** _____ **VARIABLE LIFE**

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Life Settlement Producer/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy		
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?		
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Life Settlement Producer/Provider	This column to be used by Insurance Company
Policy values as of (insert date)		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Life Settlement Producer/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)		
Date of last cost of insurance deduction		

TO BE COMPLETED BY LIFE SETTLEMENT PRODUCER/PROVIDER

The information submitted for verification by the life settlement producer/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

Signature

Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____(date).

Insurance company: _____ NAIC # _____

Printed name: _____ Title: _____

Telephone number: _____ Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____ Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____ Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- Absolute Assignment/Change of Ownership/Viatical or Life Settlement Assignment
- Change of Beneficiary
- Release of Irrevocable Beneficiary (if applicable)
- Waiver of Premium Claim Form
- Disability Waiver of Premium Approval Letter
- Release of Assignment
- Change of Death Benefit Option Form (if UL)
- Allocation Change Form (if Variable)
- Annual Report
- Current In Force Illustration