VIATICAL & LIFE SETTLEMENT PRELIMINARY APPLICATION

Veris Settlement Partners, Inc.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT IS GUILTY OF CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON.

INSURED INFORMATION

First Insured Name:____ SS #: ____________________________________

State of Primary Residence:______ Date of Birth: ______________________________ Male:________ Female:________

Street Address:__________________________ City:____________ State:__________________ Zip Code: ___________

Second Insured Name:_______________________________________ SS #: _____________________________________

State of Primary Residence:______ Date of Birth: ______________________________ Male:________ Female:________

Street Address:__________________________ City:____________ State:__________________ Zip Code: ___________

POLICY OWNER INFORMATION (IF DIFFERENT THAN INSURED)

Policy Owner (*if other than insured*): ____

Name of Officer, Trustee or Other Authorized Signatory: ____

State of Situs, Residence or Domicile: _____________Tax ID#:_____________________ Male:________ Female:_______

Street Address:__________________________ City:____________ State:__________________ Zip Code: ___________

Additional Policy Owner (*if other than insured*): ____

LIFE INSURANCE POLICY INFORMATION

Name of Insurance Company: ____

Policy Number:____ Policy Date:__________ Issue Date: __________

Type of Policy: Universal Life (____) Term (____) Whole Life (____) Group Insurance (____) Other (____)

Policy Face Amount: $___________________________________ Scheduled Premium Amount: $ ___________________

Scheduled Premium Mode (i.e. frequency of payments): __________ Policy Beneficiary:___________________________

Loan Balance, if any: $_____________________________ Current Cash Surrender Value: $ ______________________

List any Riders or Supplemental Benefits provided for in the policy (e.g. Accidental Death Benefit, Waiver of Premium, Accelerated Benefits, Maturity Extension Rider, etc.): ____________________

____

Was any portion of the policy premium borrowed (e.g. using a premium finance loan)? Yes (____) No (____)

Name of Lender/Finance Company or Premium Finance Program: ____________________

____

INSURED MEDICAL INFORMATION

Please provide a brief description of the insured's past and present medical condition(s) and the dates of first diagnosis:

____

____

____

Name of Primary Care Physician: ____________________

Current Address: ____________________

____

City: __________ State: ______ Zip: ________ Telephone #: ____________________

Fax #: ____________________

Name of Specialist: ____________________

Current Address: ____________________

____

City: __________ State: ______ Zip: ________ Telephone #: ____________________

Fax #: ____________________

Name of Specialist: ____________________

Current Address: ____________________

____

City: __________ State: ______ Zip: ________ Telephone #: ____________________

Fax #: ____________________

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.

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 Life 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.

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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 if 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 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

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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

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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 life settlement contract between the owner and a life settlement provider, or to effectuate the sale or transfer of a life 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 life settlement broker, (2) any life settlement provider (a "life settlement provider"), (3) any person who may seek to purchase from such life 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 life 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. Redisclosure 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.

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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

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New York Owner and Insured Disclosures

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

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

1. There are possible alternatives to life settlement contracts, including any accelerated death benefits or policy loans offered by the issuer of the policy.

2. Some or all of the proceeds of a life settlement may be taxable under federal and state law and advice should be sought from a professional tax advisor.

3. Proceeds from a life settlement could be subject to the claims of creditors.

4. Receipt of the proceeds from a life settlement contract may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements, and advice should be obtained from the appropriate agencies.

5. The Owner has the right to rescind (cancel) a life settlement contract from the time of execution of the contract until fifteen (15) days after the receipt of the life settlement proceeds by the owner.

6. Proceeds will be sent to the Owner within three (3) business days after the life settlement provider has received the insurer or group administrator's acknowledgment 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.

7. 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 and assistance should be sought from a professional financial advisor.

8. The owner has the right to know the gross offer or bid that the life settlement provider shall pay pursuant to the life settlement contract; the net amount to be paid to the owner pursuant to the life settlement contract; the name of each life settlement broker, life settlement intermediary, insurance producer or insurance consultant that will be compensated by the life settlement provider, or any affiliate, parent corporation, or subsidiary of the life settlement provider; and the amount of compensation that the life settlement provider, or any affiliate, parent corporation or subsidiary of the life settlement provider, shall provide to a life settlement broker, life settlement intermediary, insurance producer or insurance consultant, or any affiliate, parent corporation or subsidiary of such broker, intermediary, producer, or consultant pursuant to the life settlement contract. For the purpose of this paragraph, "gross offer or bid" means the total amount or value offered by the life settlement provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

Policyowner's initials ______

Insured's initials ______

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9. The date by which the funds will be available to the Owner and the transmitter of the funds.

10. The life settlement provider or life settlement broker is required to provide an owner during the solicitation process with a consumer information booklet in a form prescribed by the New York Superintendent of Insurance, or other similar material, subject to the approval of the New York Superintendent of Insurance.

11. The insured may be contacted by either the life settlement provider or the life settlement broker, or any authorized representative thereof, for the purpose of determining the insured's health status or to verify the insured's address, and that the contact shall be limited is limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

12. The life settlement provider must provide you, the owner, the right to know any affiliations or contractual arrangements between the life settlement provider and the issuer of the policy to be settled.

13. The life settlement provider must provide you, the owner, the right to know any affiliations or contractual arrangements with any other life settlement provider, life settlement broker, life settlement intermediary or party financing the transaction.

14. A life settlement broker represents exclusively, the owner, and not the insurer or the life settlement provider, or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

15. The life settlement provider must provide you, the owner, the right to know the name, business address, telephone number and e-mail address of the independent, third party escrow agent and that the owner has the right to inspect or receive copies of the relevant escrow or trust agreements or documents.

16. A change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

17. The life settlement provider must provide you, the owner, the right to know the name, business address, telephone number and e-mail address of the life settlement provider.

18. 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 family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement contract between the Owner and 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 two years.

Policyowner's initials ______

Insured's initials ______

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New York 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

Life Settlement Broker

Printed Name Signature Date

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

Printed Name Signature Date

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**

Form VOC

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