INTEGRITY SETTLEMENT GROUP
LIFE SETTLEMENT APPLICATION

PERSONAL INFORMATION

First Insured Name ______________________________ Sex: Male ( ) Female ( )

First Insured Date of Birth ____________ Social Security Number ____________________

Second Insured Name ______________________________ Sex: Male ( ) Female ( )

Second Insured Date of Birth ____________ Social Security Number ____________________

Address____

City______________________________ State__________ ZIP__________

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( ) Currently Employed: Yes ( ) No ( )

Have you been or are you a party to: Civil Suit? ( ) Bankruptcy? ( ) Judgements? ( ) Credit Liens? ( ) Tax Liens? ( )

LIFE INSURANCE POLICY INFORMATION

INSURED: FIRST ( ) SECOND ( ) BOTH ( ) – SECOND TO DIE

Insurance Company: ____

Policy #: ____________________ Policy Issue Date: ____________________

Face Value: $__________ + Paid Up Additions: $ __________ = Death Benefit: $__________

Cash/Account Surrender Value: $ __________ Policy Loan: $__________ Maturity Date: __________

Premium Payment: $ __________ Mode?: Annual ( ) Semi Annual ( ) Quarterly ( ) Monthly ( )

Type of Policy? Term ( ) Whole Life ( ) Universal Life ( ) Other? ____________________

Policy Owner?: Insured ( ) Other ( ) If other, please complete following:-

Trust/Corp/Individual Name: ______________________________ State:__________

SS#/TIN# ____________________ Trustee/Contact Name: ______________________________

Beneficiary?: Policy Owner - Yes ( ) No ( ) If No, who is the Beneficiary? ____________________

MEDICAL INFORMATION – FIRST INSURED

This summary is used for cross checking with the medical records to ensure that we have all necessary information.

FIRST INSURED NAME: ______________________________ **SS#** ____________________

Name of Primary Physician ______________________________ Medicals $__________

Medical Facility: ____

Address ____

Tel: (______) ____________________ Fax: (______) ____________________ email ____________________

Medical Conditions ____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION (HIPAA COMPLIANT)

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person ("Authorized Discloser") to provide Integrity Settlement Group or its designee ("Authorized Recipient"), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me (hereinafter, "Protected Health Information" or "PHI").

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 patient, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the patient, along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in the possession and control of the Authorized Discloser.

By signing below, I understand that this Authorization shall apply to any and all PHI, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I further understand that PHI obtained may be used to evaluate eligibility to participate in Purchaser's life settlement program and to evaluate life expectancy now and in the future. Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this Authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), 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 further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters.

I understand that I may revoke this Authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of the revocation in writing and delivering such revocation by certified mail or personal delivery at such address designated by the respective Authorized Discloser.

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"), and that PHI obtained by this Authorization, if redisclosed by authorized Designee, may no longer be protected by the HIPAA Privacy Regulations.

FIRST INSURED **DATE:** ________________________________

X____ ____

Signature of the FIRST Insured **Name of the FIRST Insured**

____ ____

Date of Birth **Social Security Number**

____ ____

Driver's License - State **Driver's License - Number**

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

I hereby authorize ____ ,

the issuer of Policy Number ____

and/or Certificate Number____

owned by ____

and insuring the life of ____

to release to Integrity Settlement Group all information about the above referenced policy including, but not limited to, the following upon its request: a copy of the policy including the application for insurance, forms, riders, amendments, policy illustrations, annual statements, premium information and verification of coverage.

This Authorization will remain in force until the earlier of: (1) one year from the date signed; (2) consideration of my application has been completed; or (3) it is withdrawn by me pursuant to applicable law. I further urge that this request be responded to in a timely fashion, as it has a significant bearing on personal and financial matters. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original.

FIRST INSURED **DATE:** ________________________________

X______________________________________
Signature of the FIRST Insured

____
Name of the FIRST Insured

POLICY OWNER – If other than Insured **DATE:** ______________________________

X______________________________________
Authorized Signature of Policyowner ***if other than Insured***

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Name and Title/Relationship of Signatory ***if other than Insured***

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Driver's License - State

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Driver's License - Number

X______________________________________
Authorized Signature of Policyowner ***if other than Insured***

____
Name and Title/Relationship of Signatory ***if other than Insured***

____
Driver's License - State

____
Driver's License - Number

X______________________________________
Authorized Signature of Policyowner ***if other than Insured***

____
Name and Title/Relationship of Signatory ***if other than Insured***

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Driver's License - State

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Driver's License - Number

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Name of Policyowner – Entity/Corp/Trust ***if other than Insured*** **with Tax ID Number**