# Integrity
CAPITAL PARTNERS

## Premium Finance Application

### PERSONAL INFORMATION

Name of Proposed Insured _____ Sex: Male ( ) Female ( )

Date of Birth _____ Social Security Number _____

Net Worth _____ Marital Status? _____ Smoker? _____

Address _____ City _____ State _____ ZIP _____

Best way to contact you: Home Tel: (_____) _____ Cell/Work Tel: (_____) _____

### LIFE INSURANCE POLICY INFORMATION

Table rating offered on last application for life insurance? _____

Insurance Company _____ Date _____ Reason _____

PLEASE LIST ANY CURRENT IN-FORCE LIFE INSURANCE POLICIES

Insurance Company _____ Face Value $_____

Insurance Company _____ Face Value $_____

Insurance Company _____ Face Value $_____

### MEDICAL INFORMATION

Primary Physician _____ Tel: (_____) _____

Address _____ City _____ State _____ ZIP _____

Medical Conditions: _____ Date of last visit _____

PLEASE LIST ANY OTHER PHYSICIANS SEEN IN THE LAST FIVE YEARS

1. Name _____ Tel: (_____) _____

Address _____ City _____ State _____ ZIP _____

Reason seen _____ Date of last visit _____

2. Name _____ Tel: (_____) _____

Address _____ City _____ State _____ ZIP _____

Reason seen _____ Date of last visit _____

3. Name _____ Tel: (_____) _____

Address _____ City _____ State _____ ZIP _____

Reason seen _____ Date of last visit _____

# 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 Capital Partners, LLC. 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.

**PROPOSED INSURED** **DATE:** _____

**X**_____ _____

**Signature of Proposed Insured** **Name of Proposed Insured**

_____ _____

**Date of Birth** **Social Security Number**

# Integrity Capital Partners Medical History Form

1) Height___ feet ____ inches Weight ____ lbs

2) Do you smoke cigarettes? _____ yes ___no

a. If "no", never smoked __ stopped smoking mo.__ yr. ___
number of cigarettes formerly smoked per day_____

3) Do you use nicotine in any other form? __ yes __ no

a. If "yes"___ pipe ___ cigar ___ chew ___ other

4) Is proposed insured currently under medication or treatment for any disease, condition or disorder?
___yes ___ no

5) Has the proposed insured ever had?

a. Any physical or mental impairment? Describe fully
___yes ___ no

b. Insurance or reinstatement declined, postponed, limited or offered on a special class basis?

c. Any past, present or expected aviation activities or hazardous sports, avocation or hobbies? Give frequency, type, special hazards. ___yes ___ no

d. Heart problems? (murmur, pain or pressure in chest, shortness of breath, stent, bypass or heart attack) If "yes" provide details in #9. ___yes ___ no

e. Treatment for high blood pressure?
___yes ___ no

f. Diabetes? If "yes" provide details in #9.
___yes ___ no

g. Cancer or tumor? If "yes" provide details in #9.
___yes ___ no

h. Epilepsy, fainting spells, nervous or mental condition or any disorder of brain or nervous system?
___yes ___ no

i. Disorder of lungs or respiratory system?
___yes ___ no

j. Disorder of stomach, intestine, rectum, liver, kidney or gall bladder? ___yes ___ no

6) Is proposed insured a U. S. Citizen?
___yes ___ no

7) Has proposed insured used narcotics, sedatives or tranquilizers not prescribed by an M.D.?

8) Does proposed insured consume alcohol? If so how often? ___yes ___ no

9) Please provide details to all "yes" answers (include question number, name & addresses of all treating physicians/hospital, dates, etc.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

# Integrity
CAPITAL PARTNERS

**FINANCIAL STATEMENT** ____

## ASSETS

**Checking and Savings** _____

**Securities: Stocks, Mutual Funds (Market Value)** _____

**Bonds (Market Value)** _____

**Retirement Accounts (401K, IRA)** _____

**Other Investments (Market Value)** _____

**Real Estate (Market Value)** _____

**Vehicles (Auto, Boat, Plane, etc.)** _____

**Personal and Home Assets** _____

**Other** _____

**TOTAL ASSETS** _____

## LIABILITIES

**Real Estate Loans/Mortgages Payable** _____

**Vehicles (Auto, Boat, Plane, etc.)** _____

**Credit Card Debt** _____

**Loans Payable** _____

**Other Liabilities** _____

**TOTAL LIABILITIES** _____

**NET WORTH** _____

# Authorization for Release of Information

I hereby authorize *Brokers Insurance* ("my Representative") and its staff, affiliated companies, and/or entities, insurance companies and their re-insurers, to possess, obtain and/or re-disclose my existing personal financial and health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications by *Brokers Insurance*, affiliated insurance companies and their re-insurers. The records may be transmitted via US regular mail, various overnight mail services and through the use of secured electronic devices.

By my signature below, I terminate any agreements I have made with my Providers to restrict any medical records and any associated HIPAA protected health information and I instruct my Providers to release and disclose my entire medical records without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer is covered by certain federal rules governing privacy and confidentiality of health information.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that this authorization permits *Brokers Insurance* to disclose my existing personal financial and health information to all or any insurance company, including but not limited to the following companies:

AIG/AG
American Equity
AXA/MONY
American Mayflower
American National
AmerUs Life
Assurity
Aviva
Banner Life
Companion Life
Coventry First
CRL Labs
Genworth Financial
Hartford Life
IBU Inc.
ING Companies
Indianapolis Life
Jefferson Pilot
John Hancock
Lincoln Benefit
Lincoln Financial
Monumental Life
Metropolitan Life
North American
Nationwide Provident
Old Mutual/F&G
Old Republic
Penn Mutual
Phoenix Life
Physicians Life
Principal Financial
Protective Life
Prudential
The Rumson Group
RSA Medical
The Standard
Sun Life
Transamerica
US Financial
US Life
Union Central
United of Omaha
West Coast Life
William Penn

I understand that I may write my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

I understand that if I refuse to sign this authorization, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments.

_____
Proposed Insured's Name

_____
Proposed Insured's Signature

_____
Agent/Witness Signature

_____
Date

Affiliated companies will treat the information regarding your insurability as confidential. They and their reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is (617) 426-3660.

The companies and their reinsurers may also release information in their files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.