5957 Freeport Boulevard
Sacramento, CA 95822
916-424-4839; 916-424-4854 FAX
www.nexussolution.com

LIFE SETTLEMENT APPLICATION

INSURED INFORMATION

______________________________ -- --- -- __________ / / / ______________________

Name of Insured Social Security Number Date of Birth Gender: Male □ Female □

Phone Number:___________________________

Permanent Residence Address City State Zip Code

____ Citizenship: US □ Other □

Length of Time at Address

Height: ____________________Weight:____________________ Tobacco Use: Smoker □ Non-Smoker □

Description of Medical History & Condition(s)

____

INSURED PRIMARY PHYSICIAN

____

Name of Primary Physician & Specialty Phone Number

Date and Reason Last Seen

Address City State Zip Code

INSURED SPECIALIST OR OTHER PHYSICIAN

____Na
me of Specialist Physician & Specialty Phone Number

____Dat
e and Reason Last Seen

Address City State Zip Code

HOSPITALIZATION INFORMATION

Name of Hospital

Date and Reason for Hospitalization

Address City State Zip Code

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LIFE INSURANCE POLICY INFORMATION

Name of Insurance Company | Policy Number | Policy Date (mo/dd/yr)

Face Amount | Account Value | Total Policy Loan | Cash Surrender Value

Type of Policy (check all that apply) TERM □ UL □ SUL □ VUL □ SVUL □ WL □ SWL □ INDEX □

Annual Premium | Premium Mode | Last Premium Paid (mo/dd/yr) | Next Premium Due (mo/dd/yr)

Name of Beneficiary(s) | Reason for Policy Sale

SELLER INFORMATION (INDIVIDUAL)

Name of Seller | Social Security Number | Date of Birth (mo/dd/yr) | Gender Male □ Female □

Permanent Residence Address | City | State | Zip Code

Marriage Status: Single □ Married □ Divorced □ Legally Separated □ Widowed □

SELLER INFORMATION (TRUST)

Name of Trust | Tax ID Number | Date of Trust (mo/dd/yr) | State Law Governing Trust

Na
me of Trustee | Social Security Number | Date of Birth (mo/dd/yr) | Gender Male □ Female □

Address | City | State | Zip Code

SELLER INFORMATION (CORPORATE)

Name of Corporation | Tax ID Number | Date of Incorporation (mo/dd/yr) | State of Domicile

Name of Authorized Office & Title | Social Security Number | Date of Birth (mo/dd/yr) | Gender Male □ Female □

Corporate Address | City | State | Zip Code

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LIFE SETTLEMENT APPLICATION

AUTHORIZATION

Please include this authorization to release records and policy information with this application.

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives of the below listed companies any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to the below listed companies the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Nexus Solutions, Inc., in connection with obtaining a decision to purchase and/or sell one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Nexus Solutions, Inc., with any information, illustrations and/or forms in connection with any life insurance policy under which my life is insured (including any conversion thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

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, any of my medical information disclosed by any Authorized Discloser to Nexus Solutions, Inc., may be redisclosed and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained in this Authorization is true and correct. I further certify that this /Authorization is written in plain language and I fully disclose its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, that date one year following the date of my death.

SIGNATURES - AUTHORIZED DISCLOSURES

____
Name of Insured (Print) Signature of Insured Date (mo/dd/yr)

____Da
te of Birth (mo/dd/yr) Social Security Number

____
Name of Second Insured (Print) Signature of Second Insured Date (mo/dd/yr)

____
Date of Birth (mo/dd/yr) Social Security Number

____
Name of Owner/Seller (if other that insured) Signature of Owner/Seller Date (mo/dd/yr)

____
Social Security Number OR Tax ID Number of Owner Signature of Financial Advisor Date (mo/dd/yr)