

EWING LIFE
SETTLEMENTS
LIFE SETTLEMENT APPLICATION

A. PERSONAL INFORMATION - INSURED (PRINT OR TYPE)

Name of Insured: _____ Gender: _____

Date of Birth: _____ SSN: X X X - X X - _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

If Married, Name of Spouse: _____ Dependent Children? _____

Complete for Second Insured, if applicable.

Is the Second Insured deceased? _____

Name of Insured: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower): _____

If Married, Name of Spouse: _____ Dependent Children? _____

A. MEDICAL INFORMATION

Medical History Summary of Insured:

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Complete for Second Insured, if applicable.

Medical History Summary of Insured:

Primary Physician: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

Specialist: _____ Telephone number: _____

For additional medical or physician information, please provide a supplementary page.

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B. LIFE INSURANCE INFORMATION

Insurance Company _____ Policy Number _____

Face Amount: _____ Date of Issue: _____

Policy Type (Term, UL, WL, SUL, SWL, VUL, Other): _____

Annual Premium Amount: _____ Premium Due Date: _____

Last Premium Paid Date: _____ Amount Paid: _____

Has the policy or any of the policy premiums been financed? _____

C. PERSONAL INFORMATION – OWNER

Is the Insured also the Owner? _____

Complete if Owner is an individual not also the Insured.

Name of Owner: _____

Authorized Representative (if business): _____

State of Formation (if business): _____

Relationship to Insured: _____

Date of Birth: _____ SSN/TIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

Has the Owner ever declared bankruptcy? _____

Is this policy being used to secure a support obligation (e.g. alimony/child support)? _____

D. D. PERSONAL INFORMATION – BENEFICIARY(IES)

Name of current Beneficiary: _____

Relationship to Insured and Owner: _____

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The undersigned represents to Ewing Life Settlements LLC that:

- A. All the information contained herein is complete and accurate and may be relied upon by Ewing Life Settlements LLC ("ELS") and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives
- B. The undersigned will immediately notify ELS of any material change in any information contained herein, occurring prior to conclusion of the proposed policy sale, including but not limited to: lapse, surrender or rescission of the policy, assignment of ownership or collateral assignment of the policy, and any change in beneficiary or creation of irrevocable beneficiary of the policy.

FRAUD WARNING

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

NOTICE TO APPLICANTS

Neither ELS nor its officers, directors, or principals provide legal, accounting, estate planning, tax or financial advice to prospective applicants regarding the advisability or relative merits of selling a life insurance policy.

An Owner must determine the benefits, detriments, risks and tax consequences of selling a life insurance policy solely in reliance upon the Owner's own attorney, accountant, or other appropriate professional advisors, only then, should a decision be made to sell a life insurance policy.

Owner has a clear and complete understanding of the current or future benefits of the life insurance policy being considered for sale. Each of the Owner and Insured(s) acknowledges that he/she has freely and voluntarily provided the information requested in this application.

The undersigned acknowledges they have read and fully understand this Life Settlement application.

OWNER/SELLER

Signature: _____

Printed Name: _____

Date: _____

OWNER/SELLER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

**AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION
PERMISSION TO SHARE INFORMATION**



Patient's Name <i>(please print)</i> :	Date of Birth:	Medical Record Number <i>(if known)</i> :
Address:	Telephone Number:	Social Security Number:

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From / Between (Circle): Name: _____ Address: _____ _____ Fax Number: _____ Telephone Number: _____	To / Between (Circle): Name: _____ Address: _____ _____ Fax Number: _____ Telephone Number: _____
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I, ***(Name of Individual)***, authorize 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:

Authorized Date of Service Range: _____ (start) to _____ (end).

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, Pharmacy Benefit Manager, any other type of health care provider, and any other person, company or institution (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 a photo static 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 Ewing Life Settlements LLC ("Ewing"), LS Hub, any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, Page 2

4. Purpose of Disclosure: This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition and life expectancy in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my life, health or medical status and condition in connection with any life insurance policy under which my life is insured.

5. Expiration: I understand this authorization will remain until the later of two (2) years after the date of my signature below or one (1) year after the date of my death.

6. 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; or by notifying Ewing in writing, addressed as set forth below. Notices shall be deemed given as of the date received or on the date shown on the receipt or confirmation therefor.

Records Mailing Address: LS Hub, 700 Stevens Ave, Unit A, Oldsmar, FL 34677

7. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision 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 the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the 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 and retained a copy of this signed authorization for future reference.

PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Date: _____

PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

(For example: Power of Attorney, Guardian ad Litem or similar status. Please attach a copy any official document confirming this status.)



LIFE INSURANCE INFORMATION RELEASE FORM

Policy Owner: _____
Insured: _____
Policy Number: _____
Insurance Carrier: _____

I hereby authorize my insurance company to furnish Ewing Life Settlements LLC and/or any of their affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, any and all information, verbal or written, including any life insurance policy illustrations, verifications of coverage, policy and application forms, riders or amendments related to the life insurance policy identified above.

I specifically authorize and request my life insurance company to rely upon a photo static or facsimile copy or other reproduction of this authorization as valid as the original authorization.

I agree and acknowledge this authorization shall remain valid for two (2) years after the date of my signature below.

POLICY OWNER

POLICY OWNER

Signature: _____
Printed Name: _____
SSN/Tax ID: _____
Date: _____

Signature: _____
Printed Name: _____
SSN/Tax ID: _____
Date: _____



AUTHORIZATION OF POLICYHOLDER AND INSURED
FOR USE AND DISCLOSURE OF NON-PUBLIC PERSONAL INFORMATION
FOR EFFECTUATION OF A LIFE SETTLEMENT TRANSACTION

In order to effect a potential life settlement contract for Life Insurance Policy Number _____ owned by _____ ("Policyholder") insuring the life of _____ ("Insured") (the "Policy"), each of the undersigned Policyholder and Insured hereby irrevocably authorizes Ewing Life Settlements LLC and any of their respective affiliates and any of their respective directors, officers, managers employees, agents and successors and assigns (collectively, the "LS Parties") to use, and to deliver, disclose, give, provide and release, any and all information, including without limitation, non-public personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of or insured under the Policy, that any of the LS Parties obtain, whether from the Policyholder or the Insured, any of their agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source, to any (1) life settlement provider and its employees, agents and representatives and their respective successors and assigns (collectively, a "Life Settlement Provider") or (2) any other person or entity that can under applicable law purchase the Policy without being a licensed life settlement provider, as may be necessary to effect a life settlement of the Policy.

Further, each of the undersigned hereby irrevocably authorizes each Life Settlement Provider to use and deliver, disclose, give, provide and release, any and all information, including, without limitation, nonpublic personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of and insured under the Policy, that such Life Settlement Provider may obtain from any of the LS Parties, to any financing entity, investor customer or any financing source of such Life Settlement Provider as may be necessary to effect a life settlement of the Policy.

Each of the undersigned hereby agrees and irrevocably consents that this Authorization shall be effective from the date hereof until two (2) years after the date hereof. Each of the undersigned hereby agrees that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may

POLICY OWNER

POLICY OWNER

Signature: _____

Signature: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

INSURED

INSURED

Signature: _____

Signature: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

This signature page may be duplicated if there are more than two (2) policy owners.

**State of California
Department of Insurance
Life Settlement Licensee**

Disclosure to Life Settlement Applicant

(To be provided no later than at time of application for any life settlement contract)

IMPORTANT: READ THIS DISCLOSURE FORM BEFORE SIGNING ANY LIFE SETTLEMENT CONTRACT.

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

1. There may be possible alternatives to life settlements which exist and include, but are not limited to, accelerated benefits options that may be offered by your life insurer.
2. Some or all of the proceeds of a life settlement may be taxable. Assistance should be sought from a professional tax adviser.
3. There may be an impact on the receipt of public assistance. The recipient should contact the State Department of Health Care Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code for further information.
4. Proceeds from a life settlement could be subject to the claims of creditors.
5. 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. Assistance should be sought from a financial adviser.
6. Entering into a life settlement could limit the insured's ability to purchase life insurance in the future because there is a limit to how much coverage insurers will issue on one life.
7. The owner has a right to rescind a life settlement contract within thirty (30) days of the date it is executed by all parties and the owner has received all required disclosures, or fifteen (15) days from receipt by the owner of the proceeds of the life settlement, whichever is sooner. Rescission will only be effective if both notice of rescission is given and all proceeds and any premiums, loans, and loan interest paid on account of the provider are repaid within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.
8. Proceeds will be sent to the owner within three (3) business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy of the interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

9. All medical, financial, or personal information solicited or obtained by a provider or 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 (2) years.
10. The insured may be contacted by either the provider or the broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact 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.
11. The broker represents the owner, exclusively, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act at any times according to the owners' instructions and in the best interest of the owner.
12. The name, business address, and telephone number of the life settlement broker are as follows:
- _____
- (brokers' printed name)
- _____
- (address)
- _____
- _____
- _____
- (telephone number)
13. The following affiliation(s) or contractual relation(s) exists between the provider and the broker: _____.
14. The following affiliation(s) or contractual relation(s) exists between the provider and with the issuer of the policy to be settled: _____.

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received a copy of this disclosure to keep for my records.

LIFE INSURANCE POLICY OWNER

By: _____
Printed Name: _____
Date: _____

LIFE SETTLEMENT PROVIDER OR BROKER

By: _____
Printed Name: _____
Date: _____