LIFESETTLEMENT ADVISORS

4630 Lisborn Drive Carmel, IN 46033
tel 1.888.849.0887 fax 1.317.842.6760
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Life Settlement Questionnaire

Part A: PRIMARY CONTACT

Name_____Email_____

Primary Phone #_____Alternate Phone #_____

Part B: POLICY INFORMATION

Life Insurance Policy Information (*Please attach additional page(s) for more than one policy*)

1. Insurance Company_____Policy #_____
2. Face Amount_____Policy Loan_____Issue Date_____
3. Type of Policy ____Term ___Universal Life ____Whole Life ____Survivorship Universal Life
   ____Survivorship Whole Life ____Variable Universal Life ____Group ____Other (please specify) _____

Policy Owner(s) Information (*Please attach additional page(s) for more than one owner*)

1. Name of Policy Owner _____
2. Contact Name (if corporate owned) _____
3. Trustee Name (if trust owned) _____
4. Social Security/Tax ID # _____
5. Address _____ City _____ State _____ Zip ____
6. Phone # _____
7. Marital Status ____Single ____Married ____Divorced ____Widowed
8. Are you a U.S. Citizen? ____Yes ____No If no, please specify country of citizenship _____

Part C: INSURED LIFESTYLE INFORMATION
(Please attach additional application for second insured)

Name _____ Phone #_____

Address _____ City _____ State _____ Zip _____

Height _____ Weight _____ Social Security # _____ Date of Birth _____Sex ___M ___F

1. Has your weight changed in the last year? If yes, provide details_____ O Yes O No
2. Do you or have you ever smoked cigarettes? If yes, provide details _____ O Yes O No
3. Do you use any other form of tobacco or nicotine? If yes, indicate type & frequency _____ O Yes O No

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4. Do you drink alcohol? If yes, indicate type & frequency _____ O Yes O No
5. Are you currently employed? If yes, indicate occupation & hours/week _____ O Yes O No
6. Are you involved in hobbies, clubs, organizations, travel or volunteer work?_____ O Yes O No
   If yes, indicate type & frequency
7. Do you have a valid driver's license? If yes, license # _____ O Yes O No
8. Do you engage in sports or regular exercise? If yes, indicate type & frequency _____ O Yes O No
9. Do you live alone? If no, with whom? ____Spouse ____Significant Other ____Other O Yes O No
10. Do you live in an assisted living facility, skilled nursing facility or nursing home? O Yes O No
    If yes, for how long? _____
11. Are you the primary caregiver for a dependent family member? O Yes O No
12. Do you require assistance to perform any of the following activities? O Yes O No
    (Check all that apply)
    ____meal planning ____taking medication ____driving ____shopping ____walking
    ____bathing ____dressing
    If yes, provide details _____
13. Do you have any children? O Yes O No
    If yes, how often do you see them? ___Daily ___Weekly ___Monthly ___Yearly ___Rarely
14. Do you have any grandchildren? O Yes O No
    If yes, how often do you see them? ___Daily ___Weekly ___Monthly ___Yearly ___Rarely
15. Do you have sleep problems? (Check all that apply) O Yes O No
    __Snoring __Difficulty Falling Asleep __Difficulty Staying Asleep __Morning Headache
    __Gasping, choking, repeated pauses in breathing while sleeping
    __Other (Provide Details) _____
16. Typical Bedtime _____# of Hours of Sleep/Night _____ # of times you get up/Night_____
17. Are you a U.S. Citizen? If no, specify country of citizenship _____ O Yes O No

Part D: MEDICAL HISTORY, CONDITIONS AND TREATMENTS

In the past five years, have you been diagnosed with or treated for any of the following conditions?
(*Please check all that apply and provide details on page four*)

1. Disease or disorder of the heart _____ O Yes O No
   __high blood pressure __atrial fibrillation __irregular pulse __other cardiac arrhythmia
   __heart attack __angina (chest pain) __coronary artery disease __valve disease __heart failure
   __other

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2. Circulatory or blood vessel disorder ..... O Yes O No
__Stroke __TIA (mini stroke) __aneurysm __arterial blockage in the neck, abdomen or legs
__venous disease such as blood clots, thrombosis or embolism __other

3. Cancer (not including non-melanoma minor skin cancer) ..... O Yes O No
__tumor or malignancy of any kind __leukemia __lymphoma __multiple myeloma
__other cancerous disorder

4. Immune system disorder ..... O Yes O No
__HIV __autoimmune disease __lupus

5. Disease or disorder of the digestive system ..... O Yes O No
__diabetes __liver disease __colon or rectum __small intestine __esophagus or stomach
__GI bleeding __other

6. Infectious disease (other than common cold) ..... O Yes O No
__hepatitis __pneumonia __sepsis __MRSA __other

7. Disease or disorder of the lungs or respiratory system ..... O Yes O No
__asthma __COPD, emphysema or chronic bronchitis
__shortness of breath at rest or with minimal exertion __chronic infection __other

8. Genitourinary problems, disease or disorder ..... O Yes O No
__breasts __prostate __bladder __kidney disease/failure __other

9. Abnormality of the blood, platelets or blood forming organs ..... O Yes O No
__anemia __high cholesterol or triglycerides __myelodysplastic syndrome
__abnormalities of platelets, white or red blood cells __abnormal bruising, bleeding or clotting
__disorder of the spleen, bone marrow or lymph nodes __other

10. Bone, joint or nerve abnormality, injury or accidental fall ..... O Yes O No
__paralysis or physical impairment __trauma or injury __problems with balance or walking
__accidental fall __arthritis __fracture of hip, vertebra or other bone __other

11. Neurological disorder ..... O Yes O No
__Parkinson's disease __multiple sclerosis __ALS __loss of consciousness
__convulsions or epilepsy __neuropathy __chronic pain __sleep apnea __other

12. Mental or nervous disorder ..... O Yes O No
__memory or cognitive impairment without dementia
__Alzheimer's or other type of dementia __depression __anxiety __schizophrenia __other

13, Alcohol and/or drug use ..... O Yes O No
__alcoholism or alcohol abuse __illegal drug use __marijuana __prescription drug abuse
__advised by a medical professional to reduce or eliminate alcohol or drug use,
including prescription drugs __inpatient treatment for drug or alcohol use

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14. Have you ever had a transplant of any organ or tissue, been diagnosed with, been treated for, had surgery, or are currently being treated for any other disease or disorder, or had an accident or injury not previously listed? ..... O Yes O No

15. Health screen history (*if known*)
Blood pressure _____Cholesterol _____ Blood Sugar _____ Ejection Fraction _____

SPECIFIC DETAILS

For any condition checked in Part D, please provide full details including diagnosis, date of diagnosis, date last treated, type of treatment(s) received, results, and additional details. (*Attach additional page(s) if necessary*)

Diagnosis _____ Date of Diagnosis _____

Type of treatment received _____Date last treated _____

Results _____

Diagnosis _____ Date of Diagnosis _____

Type of treatment received _____Date last treated _____

Results _____

Diagnosis _____ Date of Diagnosis _____

Type of treatment received _____Date last treated _____

Results _____

Diagnosis _____ Date of Diagnosis _____

Type of treatment received _____Date last treated _____

Results _____

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PART E: FAMILY HISTORY AND PRESCRIPTION MEDICATION

1. Family History (Attach additional pages(s) if necessary)

	Age, if living	Age at death	Cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Spouse	_____	_____	_____
Child	_____	_____	_____
Child	_____	_____	_____

2. Do you take any medications currently?_____ ____Yes ____No

Please include over the counter (OTC) medications and vitamins (*Attach additional page(s) if necessary*)

Medication name _____How long prescribed _____
For what condition _____Dosage and frequency _____

Medication name _____How long prescribed _____
For what condition _____Dosage and frequency _____

Medication name _____How long prescribed _____
For what condition _____Dosage and frequency _____

Medication name _____How long prescribed _____
For what condition _____Dosage and frequency _____

PART F: PHYSICIAN INFORMATION

1. Primary Care Physician

Name _____Phone __(_____)_____
Address _____ City _____State _____ Zip _____
Date of last visit _____ Reason for last visit _____

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2. Specialty Care Physician
List those who have treated you in the last five years (*Attach additional page(s) if necessary*)

Name _____ Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Date of last visit _____ Reason for last visit _____

Name _____ Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Date of last visit _____ Reason for last visit _____

Name _____ Phone (_____) _____
Address _____ City _____ State _____ Zip _____
Date of last visit _____ Reason for last visit _____

I hereby acknowledge that LSA may provide this questionnaire and any and all information provided herein, including my personal and/or heath related information to LSA's affiliates, as well as non-affiliated contracted parties, for the purpose of evaluating and qualifying for a life settlement, one or more life insurance policies under which my life is insured.

I hereby represent and warrant that any and all information provided by me in this questionnaire is true and correct as of the date hereof. I hereby affirm my understanding that LSA, any of its affiliates, and/or any of their respective directors, offices, employees, agents, independent contractors, service providers or other authorized representatives (each, and "Indemnified Person") will be relying on the statements and responses made by me in this questionnaire, and I agree to hold each Indemnified Person harmless and agree to indemnify each Indemnified Person from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

_____

Name of Insured Signature of Insured Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH AND POLICY INFORMATION
(HIPAA COMPLIANT)

The undersigned insured (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 ("HIPAA"), as follows:

Permission to Obtain Information: I hereby authorize any health plan, physician, nurse, health care professional, hospital, clinic, laboratory, medical facility, insurance company, insurance support organizations (such as MIB, Inc.) or any other health care provider, individual, or institution (each, a "Provider") to provide Life Settlement Advisors, LLC, and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives (collectively, "LSA") regarding a life insurance policy of which I am the owner or the insured, with any and all medical records and information as to the symptoms, examination, diagnosis, treatment and prognosis with respect to any physical or mental condition, including HIV/AIDS infections, sexually transmitted diseases, psychiatric conditions (excluding psychotherapy notes), and drug, alcohol, or tobacco abuse, of or relating to the insured.

Disclosure, Inspection, and Copying of Records: 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 treatments or hospitalization of the insured, including but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or physician notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

Release of Policy Information: I understand and acknowledge that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my insurance company to furnish LSA with any information herein described.

Nature of Information Collected: I understand that the information collected under this authorization will be used by LSA for the distribution to insurance carrier(s) and settlement companies to evaluate my application to sell a life insurance policy of which I am the owner or the insured. I understand that life settlement providers, their medical underwriters, reinsurers or other entities which require health information in order to complete a life settlement transaction will use the information released or obtained pursuant to this authorization for the purpose of completing the sale of a life insurance policy of which I am the owner or the insured, and I hereby expressly authorize such use and disclosure of my information made under this authorization.

Duration and Revocation: This authorization shall remain valid until, and shall expire on, the date one year following the date of my death, 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 there under. I understand I have the right to revoke this authorization in writing, at any time, by sending a written notice of revocation to Life Settlement Advisors, LLC, 4630 Lisborn Drive, Carmel, IN 46033. I understand that a revocation is not effective to the extent that any of my Providers have taken action in reliance upon this authorization prior to receiving notice of my revocation, or to the extent that LSA and the Carrier(s) have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse, or health care plan, and any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Life Settlement Advisors, LLC will protect the privacy of health insurance in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508(c)(1)(iv) of the HIPAA. I understand that my Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Life Settlement Advisors, LLC and the carrier(s) may not be able to process my application. I understand that I have a right to receive a copy of this authorization, and I agree that a photocopy or facsimile of this authorization shall be valid as the original. I also acknowledge receipt of Disclosure Notice to Applicants for Insurance. I certify that this authorization is written in plain language, and I am executing and delivering this authorization freely and unilaterally as of the date written below. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

This Authorization Signed at _____ this _____ day of _____ , 20 ____.

_____
Insured Name

_____
Insured Signature

_____
Witness