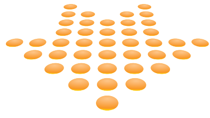


SETTLEMENT APPLICATION

A. PERSONAL INFORMATION (Please Print or Type)

Insured's Name | Date of Birth | Social Security Number

2nd Insured's Name | Date of Birth | Social Security Number

Address | Phone Number

City | State | Zip Code

B. LIFE INSURANCE INFORMATION

Insurance Company | Policy Number | Face Amount

Date of Issue | Policy Type (WL, UL, SUL, Term, etc...) | Current Premium

Policy Owner | State of Residence | Beneficiary(s)

Is the policy owner a defendant in any suits or legal actions? ❑ Yes ❑ No

Has the policy owner ever declared bankruptcy? ❑ Yes ❑ No

Marital Status: ❑ Single/Never Married ❑ Married ❑ Widowed ❑ Divorced

C. MEDICAL INFORMATION

Insured Medical History

2nd Insured Medical History

Primary Physician | Telephone Number

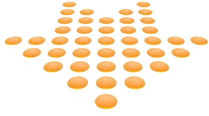
Address

City | State | Zip Code

Specialist | Telephone Number

For additional policy and/or physician information, please provide a supplementary page.

For Agent Use: If available please include the following: 1) Current in force Illustration to maturity. 2) Current APS (if not within the last 90 days, please provide physician information in Section C).



The undersigned represents to Cambridge Settlements, LLC that:

A: The information contained herein is complete and accurate and may be relied upon by Cambridge Settlements, LLC, Life Settlement/Viatical Settlement Brokers and Financing Sources.

B: The undersigned will immediately notify Cambridge Settlements, LLC of any material change in any information contained herein, occurring prior to conclusion of the proposed sale, including but not limited to: cancellation and release of insurance policies, assignment of ownership of policies, change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies.

The proposed sale, cancellation and release of insurance policies, assignment of ownership of policies, or change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies will be solely for the benefit and account of the undersigned, and not for the account or benefit of any other person.

FRAUD WARNING

Any person who knowingly presents false information in an application for insurance or an application for a life settlement/viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO APPLICANTS

Neither Cambridge Settlements, LLC nor its officers, directors, or principals provide legal, accounting, or financial advice to prospective applicants regarding the advisability or relative merits of selling or conveying their legal rights in existing life insurance policies in exchange for cash payments referred to as living benefits, viatical settlements, intervivos settlements, or other similar terms.

An applicant must determine the relative benefit of any such living benefit settlement after review of the legal and financial implications of such a settlement with the applicant's own attorney, accountant, or other appropriate advisors, only then, should a decision be made to effect such a sale or settlement.

Applicant has a clear and complete understanding of the current or future benefits of the life insurance policy being offered for sale or settlement.

Applicant acknowledges that he/she has freely and voluntarily provided the information requested in this application.

PLEASE SEND WITH THE COMPLETE APPLICATION FORM, PHOTOCOPIES OF THE FOLLOWING:

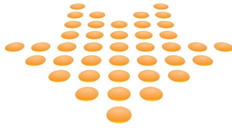
A. Life Insurance policy to be sold, including the application for insurance

B. Your Driver's License

C. Last premium statement from your Life Insurance company (if available)

D. Social Security Card

______________________________	______________________________
Applicant's Full Name (Type or Print)	Applicant (Signature / Owner)
______________________________	______________________________
Applicant's Full Name (Type or Print)	Applicant (Signature)



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, 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:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (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 photostatic 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 Cambridge Settlements, LLC and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall supply 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 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, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore, that Cambridge Settlements, LLC brokers.

4. Expiration: This authorization shall remain valid until, and shall expire, one year after the date of my death.

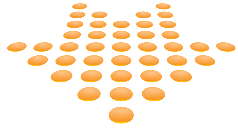
5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address 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.

6. 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.

Signature of Individual / Insured	Date	Signature of Personal Representative of Individual	Date
Print or Type Name of Individual	Date	Description of Personal Representative's Authority (Power of Attorney, Gaurdian ad Litem or similar status)	Date



CambridgeSolutions

LIFE INSURANCE INFORMATION RELEASE FORM

Life insurance policy number ______________________________

issued by ______________________________

(Insurance Company), is owned by, ______________________________

and insured the life of ______________________________

I authorize the release to Cambridge Solutions, LLC or its designee, any or all information concerning the above policy. I authorize Cambridge Solutions, LLC to share this information with brokerage general agents, and other parties, as required.

______________________________ ______________________________

Policy Owner Signature | Date

______________________________ ______________________________

Type or Print Name | Social Security Number

CambridgeSettlements

AGENT OF RECORD LETTER

I, ____

the potential seller of policy number ______________________________

insuring the life of ______________________________________

and issued by ____

insurance company, have agreed to consider the sale of this policy through a life settlement transaction.

My agent of record for the potential sale of the policy is ________________________

and the settlement agency of record is ______________________________

SELLER INFORMATION

Name of Seller / Owner	Signature	Date (mo/dd/yr)

Address	City	State	Zip

WITNESS INFORMATION

Name of Witness	Signature	Date (mo/dd/yr)