



LIFE INSURANCE BUYERS, INC.

Indiana Settlement Application

A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)

Insured's Name	Date of Birth	Social Security Number
2 nd 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	_____
2 nd Insured Medical History	_____
Primary Physician	Telephone Number
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).

LIBI.IN1

The undersigned represents to Life Insurance Buyers, Inc. that:

- A. The information contained herein is complete and accurate and may be relied upon by Life Insurance Buyers, Inc., Life Settlement/Viatical Settlement Providers and Financing Sources.
- B. The undersigned will immediately notify Life Insurance Buyers, Inc. 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 Life Insurance Buyers, Inc. nor it's 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 & 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

Date

Witness' Full Name (Type or Print)

Witness Signature

Date

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 Life Insurance Buyers, Inc. 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 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 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 Life Insurance Buyers, Inc. 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 Date

Signature of Personal Representative of Individual Date

Print or Type Name of Individual Date

Description of Personal Representative's Authority:

(Power of Attorney, Guardian ad Litem or similar status)



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 Life Insurance Buyers, Inc. (LIBI) or its designee, any or all information concerning the above policy.

I authorize LIBI to share this information with life settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life settlements, and/or life and health insurance policies.

Policy Owner Signature

Date

Type or Print Name

Social Security Number



DISCLOSURE

The owner of the life insurance policy to be viaticated, the viator, should be aware of the following:

1. That there are possible alternatives to viatical settlement contracts, including accelerated benefits offered by the issuer of a life insurance policy.
2. That tax consequences may result from entering into a viatical settlement contract.
3. That proceeds of a viatical settlement could be subject to the claims of creditors.
4. That a consequence of entering into a viatical settlement contract may include the possible interruption of assistance provided by medical or public assistance programs.
5. That a viatical settlement contract must provide for the unconditional rescission of the contract by the viator for the longer of (1) the period ending not more than fifteen (15) days after the receipt of the viatical settlement proceeds by the viator, or (2) the period ending not more than (30) days after the execution of the contract. A viatical settlement contract is rescinded if the individual dies during the rescission period, subject to repayment of all proceeds to the viatical settlement provider.
6. That entering into a viatical settlement contract may cause other rights or benefits under the policy, including conversion rights, waiver of premium benefits, family riders, or coverage of a life other than an ill individual, to be forfeited by the viator.
7. The viatical settlement provider company, not the viator or life settlor, may compensate LIBI up to a maximum of six percent (6%) of the face value of a life insurance policy. For example a viatical settlement for a \$100,000 policy would be: 6% x \$100,000 (face value) = \$6,000.00.
8. That the viatical settlement provider or viatical settlement broker may contact the insured for the purpose of determining the health status of the insured not more than one (1) time every three (3) months for an insured with a life expectancy of more than one (1) year, or one (1) time every month for an insured with a life expectancy of not more than one (1) year. Contacts must be made by mail unless the parties agree to another method of contact.

_____ Signature of Insured	_____ Date	_____ Signature of Policy Owner (Viator)	_____ Date
_____ Printed Name	_____ Date	_____ Printed Name	_____ Date
_____ Signature of Witness	_____ Date	_____ Signature of Witness	_____ Date
_____ Printed Name	_____ Date	_____ Printed Name	_____ Date
_____ LIBI Representative	_____ Date	_____ Printed Name	_____ Date