



LIFE INSURANCE BUYERS, INC.

Kansas 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 _____

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 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

Print or Type Name of Individual Date

Signature of Personal Representative 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 any accelerated death benefits or policy loans offered under the viator's life insurance policy.
2. That some or all of the proceeds of the viatical settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor.
3. That proceeds of the viatical settlement could be subject to the claims of creditors.
4. That receipt of the proceeds of a viatical settlement may adversely affect the viator's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.
5. That the viator has the right to rescind a viatical settlement contract for fifteen (15) calendar days after the receipt of the viatical settlement proceeds by the viator, as provided by Kansas law. If the insured dies during the rescission period, the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans and loan interest to the viatical settlement provider or purchaser.
6. That funds will be sent to viator within three (3) business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
7. That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator. Assistance should be sought from a financial adviser.
8. That all medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement 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 viatical settlement between the viator and the viatical settlement 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 years.



9. That the insured may be contacted by either the viatical settlement provider or viatical settlement broker or such viatical settlement provider's or viatical settlement broker's authorized representative for the purpose of determining the insured's health status. The contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

I have received the most current form of brochure describing the process of viatical or life settlements prepared by the National Association of Insurance Commissioners and provided as part of the viatical settlement disclosure.

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**