



*A New Financial Strategy For Seniors.*

## ***Application and Acknowledgement for a Life Settlement Transaction***

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*Please print applicant (insured) name.*

**To obtain the best amount for your life insurance policy, please read thoroughly  
and complete these forms.**

2500 Plaza V, 25th Floor ● Harborside Financial Center ● Jersey City, NJ 07311  
Main: (201) 633-4747 ● Toll-Free: (877) 641-5433 ● E-Fax: (201) 608-6840 ● info@alantralife.com ● [www.alantralife.com](http://www.alantralife.com)



# Life Settlement Application

Date: \_\_\_\_\_

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

To deliver the Alantra Advantage, we have streamlined the settlement process to secure the fastest, maximum settlement possible. Please note that this is a confidential application. Alantra never requires medical examinations, and we protect the confidentiality of all information by employing the strictest security measures.

Please use this **checklist** as a guide to gather and submit all required materials so Alantra can expedite your settlement.

- Completed and signed Application
- Signed Notice of Disclosure (page 8 of application)
- Signed Authorization to Release Policy Information (pages 11-12 of application)
- Signed HIPAA Compliant Release of Medical Information (pages 9-10 of application)
- Photocopy of the life insurance policy (must be Universal Life, Variable Universal Life, Whole Life, Key Man, Split-dollar, Buy-Sell, Corporate/Company Owned Life Insurance (COLI), Bank Owned Life Insurance (BOLI) or Term)
- Photocopy of insured's medical records from all physicians seen within the last four years. Please include office notes, labs, pathology reports, etc. Alantra's Advisor Liaison can assist in securing these records if necessary.
- Physicians letter of competency for Policy Owner (required for all owners or Trustees)
- Photocopy of two forms of government-issued identification for the insured (driver's license, social security card, passport, etc.)
- Photocopy of two forms of government-issued identification for the policyholder (driver's license, social security card, passport, etc.). Not applicable if policy holder and insured are the same. If the policyholder is not an individual, attach a photocopy of the trust or corporation's proof of incorporation.
- Photocopy of insured/policyholder divorce decrees, if applicable
- Photocopy of insured/policyholder bankruptcy discharge, if applicable
- Photocopy of any trust documents, if applicable
- Photocopy of two forms of government-issued identification for Trustees, if applicable
  
- Provide inforce illustration. If you are not able to obtain the illustration, Alantra will order

it with the proper authorization. Ideally, submit an inforce illustration of the following:

- Solve for minimum premium to carry the policy to maturity. Use current rates and a level death benefit

Retain a copy of all materials for your records before submitting to Alantra

All of the above documents are required to obtain settlement proposals from our funding institutions. If you do not submit all required materials, the process will be delayed.

Mail or fax materials to:            Alantra Advisor Liaison  
   Alantra Life Settlements Application Processing  
   Harborside Financial Center  
   2500 Plaza V, Suite 2500  
   Jersey City, NJ 07311  
   877-641-LIFE (5433) or 201- 633- 4747  
   Fax 201-503-8166

#### I. Process

When Alantra receives all the documents, we will begin the medical & insurance underwriting process. Please be certain to follow the checklist we had provided, so that the application and the required documentation is completed properly. If you need help in determining if your state has licensing requirements, please refer to State Regulation section in our Resource Center or contact Alantra Life Settlement for clarification.

#### II. Offer

Once the underwriting process is complete, we will negotiate with qualified funders to determine the highest offer and present it to the applicant for review.

#### III. Closing

Upon acceptance, closing documents are forwarded to owner of policy, funds are placed in escrow. Once the escrow agent has confirmed ownership changes, funds will be released from Escrow.



**APPLICATION FOR LIFE SETTLEMENT**

**POLICY OWNER INFORMATION**

Name of policy owner \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Social security or tax Id number \_\_\_\_\_

If corporate/trust owned policy:

Name of President/Trustee \_\_\_\_\_

Date of Incorporation/Trust \_\_\_\_\_

Has policy owner ever declared bankruptcy? Yes No If yes, has it been discharged?  
Yes, on this date: \_\_\_\_\_

**INSURED INFORMATION**

Check this box if insured and the policy holder are the same person and skip the grey section

First name \_\_\_\_\_ Last name \_\_\_\_\_

Social security number \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

Has the insured ever declared bankruptcy? Yes No If yes, has it been discharged?  
 Yes, on this date: \_\_\_\_\_  
 No

Driver's License Number \_\_\_\_\_ State license issued in \_\_\_\_\_

Gender:  Male  Female Marital status:  Single  Married  
 Widowed  Divorced

Have you ever smoked cigarettes: Y / N if yes, date of the last usage \_\_\_\_\_

Have you used other tobacco or nicotine containing products: Y / N  
If yes provide types and the last date of use: \_\_\_\_\_

**INSURED MEDICAL INFORMATION**

Name of primary attending physician \_\_\_\_\_

Date last seen \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Please list all other physicians seen in last 48 months [attach additional pages if necessary]

Name \_\_\_\_\_ Date last seen \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Date last seen \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Name \_\_\_\_\_ Date last seen \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Please list all hospital(s) that have treated you in the last 48 months  
[attach additional pages if necessary]

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Please provide a brief description of your medical history: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIFE INSURANCE POLICY INFORMATION**

Insurance company \_\_\_\_\_

Type of policy  Individual  UL  WL  Term  Joint survivorship  Other \_\_\_\_\_

Policy number \_\_\_\_\_ Issue Date \_\_\_\_\_

Face Amount \$ \_\_\_\_\_ Cash Surrender Value \$ \_\_\_\_\_

Policy premium paid  Annually  Semi-annually  Quarterly  Monthly Premium Amount \$ \_\_\_\_\_

Date last premium paid \_\_\_\_\_ Date next premium due \_\_\_\_\_

Has this Policy ever lapsed?  Yes  No

Was this Policy Premium Financed?  Yes  No If Yes, list source \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

What is the specific reason for the sale of this policy? \_\_\_\_\_

\_\_\_\_\_

**FINANCIAL ADVISOR INFORMATION**

Name \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail address \_\_\_\_\_

If a financial professional did not advise you, how did you learn about Alantra? \_\_\_\_\_

\_\_\_\_\_

**Personal Acknowledgements and Agreements**

I hereby represent, warrant and agree that the information contained in this application is correct and accurate to the best of my knowledge. I agree to immediately notify Alantra\* of any changes in the information contained herein. I hereby authorize Alantra and its authorized representative, to obtain all necessary medical records, notes, lab reports, credit reports and any documents needed to process this application. I further give my consent to Alantra and its authorized representatives to release this application and related records including, without limitation, records pertaining to my medical status and eligibility for a life settlement for the purpose of soliciting the sale of my life insurance policy referenced herein (the "Life Policy"). I acknowledge that I am seeking to sell my interest in the Life Policy and am submitting this application to induce Alantra to obtain the highest and best offer for the Life Policy. In the event I agree to accept an offer presented to me by Alantra for the sale of the Life Policy, I agree to pay Alantra, as a commission, the lesser of 7% of the face value of the Life Policy, or 35% of the gross offer of such sale. In the event the foregoing commission is deemed impermissible under applicable law or is limited by the life settlement provider that purchases the Life Policy, I agree that such commission shall be the maximum allowable under such applicable law or by such life settlement provider, as the case may be.

I also acknowledge and agree to hereby grant Alantra an exclusive right to represent me in the sale of the life policy for a period of 180 days beginning on the date of this application (the "exclusive period"). In consideration for my granting Alantra such exclusivity during the exclusive period and if the life policy is deemed suitable for sale in the life settlement market, Alantra will use its best efforts to solicit offers to buy the life policy in an effort to get the highest and best offer for the life policy. I further acknowledge and agree that the exclusive period hereunder shall automatically renew for successive periods of 180 days unless I provide written notice by facsimile to (201) 503-8166 no later than thirty days prior to the expiration of the initial term or any renewal term of my intention not to renew the exclusive period.

I understand that Alantra will incur certain expenses on my behalf in order to compile the information needed to solicit bids for the Life Policy including, without limitation, expenses related to the procurement of life expectancy reports, compiling required medical records, and engaging legal and other professional services as needed to structure my case to make it as marketable as possible (collectively, the "Expenses"). I further acknowledge and agree that Alantra in its sole discretion will decide when and if any Expenses related to my life settlement will be incurred including specifically the purchase of life expectancy reports on an expedited basis. I agree that I am liable for and will reimburse Alantra for the expenses incurred by Alantra if I ultimately do not sell the life policy through Alantra regardless of whether any other party has agreed to reimburse me for the expenses. I understand that any agreement or understanding I may have with my insurance agent or broker or any other person regarding the sale of the Life Policy or expenses in connection therewith will not relieve me of my obligations under this application. I further acknowledge and agree that any such agent or broker is my representative, is not acting for or on behalf of Alantra and that Alantra has no responsibility for any action of such agent or broker.

I further hereby represent, warrant and agree that I will give all reasonable cooperation to Alantra as it assists me in the sale of the Life Policy during the Exclusive Period. My cooperation will include, without limitation, (a) my not consenting to, directing, allowing or causing, directly or indirectly, any other broker, agent, person or entity to solicit offers to buy the Life Policy during the Exclusive Period, (b) immediately notifying Alantra of any marketing activity not coordinated with Alantra related to the possible sale of the Life Policy as a life settlement including any contact I might have directly or indirectly with another life settlement broker, (c) during the Exclusive Period my not entering into any agreement or application (whether written or oral) not presented to me by Alantra for the sale, solicitation for sale or promotion of the Life Policy and (d) my not taking any action that would tend to circumvent or undermine Alantra's exclusive rights under this application including, without limitation, selling, transferring or assigning the ownership or beneficial interest in the Life Policy (or insurance trust, if any) to any third party. During the Exclusive Period I irrevocably grant to Alantra the right to be my broker of record and this application shall supersede any and all other broker of record letters or agreements for this period with respect to the Life Policy. I agree that if the Life Policy is sold during the Exclusive Period in any agreement not including Alantra as my life settlement broker, such sale would constitute my breach of this application. I acknowledge that monetary damages may not be a sufficient remedy for any breach or threatened breach of this application, and that Alantra shall be entitled, without waiving any other rights or remedies, to seek such injunctive or equitable relief as may be deemed proper by a court of competent jurisdiction. I agree to not urge, as a defense to any proceeding for such specific performance or injunctive relief, that Alantra has an adequate remedy at law. I agree that it would be impracticable and extremely difficult to ascertain the amount of actual damages caused to Alantra by my breach of this application and we have therefore agreed upon liquidated damages as reasonable compensation for such a breach. If I sell, assign or transfer the Life Policy (or an interest therein) in breach of this agreement, the agreed upon liquidated damages will be the lesser of 7% of the face value of the Life Policy, or 35% of the gross offer of such sale. For any other material breach, the liquidated damages will be 5% of the Life Policy's face value.



**NOTICE OF DISCLOSURE**

To verify that Alantra Life Settlements (Alantra) has disclosed the following facts to you, please initial each of the following statements:

\_\_\_\_\_ There may be alternatives to a viatical settlement contract including, but not limited to, accelerated benefits offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance policy.

\_\_\_\_\_ Some or all of the proceeds of your settlement may be taxable. Alantra strongly urges you to consult your own attorney or tax advisor concerning this transaction. Alantra makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

\_\_\_\_\_ Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.

\_\_\_\_\_ Along with this application and its disclosures, Alantra has provided an additional information/disclosure booklet for the Policy Owner. If you have not received this booklet, please call 877-641-LIFE (5433) to have one delivered to you, otherwise you acknowledge receipt of this booklet.

This disclosure is being made to you in compliance with the State Insurance Codes, where applicable.

I, the applicant, do hereby acknowledge that I have read and understand the contents of this disclosure.

This disclosure **must be signed before a witness.**

\_\_\_\_\_  
Signature of Policy Owner

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



## **Authorization For Disclosure of Protected Health Information**

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. 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 Alantra Life, any of its respective affiliates, any of their respective agents, employees and representatives, and their respective successors and assigns (each, an "Authorized Recipient").
3. Description of 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. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) 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 any Authorized Recipient and (b) 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 that any Authorized Recipient purchases.
4. Expiration of Authorization. This authorization shall remain valid until, and shall expire on, the date that is one (1) 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. I understand that no Authorized 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 as of the date written below 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.

INDIVIDUAL: \_\_\_\_\_ Date: \_\_\_\_\_

(A copy of this form should be signed by each person insured under the life insurance policy.)

## Insured's Authorization for Disclosure of Life Insurance Policy Information

The undersigned, \_\_\_\_\_ ("the "Insured"), the insured under Life Insurance Policy Number \_\_\_\_\_ (the "Life Insurance Policy"), issued by \_\_\_\_\_ (the "Life Insurance Company"), hereby authorize(s) the Life Insurance Company and any of its agents, successors or designees or assigns, to deliver, disclose, give, provide and release to Alantra Life, any of their respective affiliates, any of their respective agents, employees and representatives and their respective successors and assigns, any and all information about the Life Insurance Policy, the Insured, including without limitation, all non-public personal financial, health and medical information concerning the Life Insurance Policy and the Insured, that the Life Insurance Company or any of its agents have in their possession or control.

This Authorization shall be effective from the date hereof until the earlier of (a) the date that is two years after the date hereof or (b) such earlier date, if any, as may be required by applicable law or regulation. The Policyowner and the Insured agree that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may be relied upon by the Life Insurance Company or any of its agents.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Insured's Social Security Number

(Include Second Insured if applicable)

\_\_\_\_\_  
Signature of 2nd Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
2nd Insured's Social Security Number

## Policy Owner's Authorization for Disclosure of Life Insurance Policy Information

The undersigned, \_\_\_\_\_ ("the "Policyowner"), the owner of Life Insurance Policy Number \_\_\_\_\_ (the "Life Insurance Policy"), issued by \_\_\_\_\_ (the "Life Insurance Company"), hereby authorize(s) the Life Insurance Company and any of its agents, successors or designees or assigns, to deliver, disclose, give, provide and release to Alantra Life, any of their respective affiliates, any of their respective agents, employees and representatives and their respective successors and assigns, any and all information about the Life Insurance Policy and the Policyowner, including without limitation, all non-public personal financial, health and medical information concerning the Life Insurance Policy and the Policyowner, that the Life Insurance Company or any of its agents have in their possession or control.

This Authorization shall be effective from the date hereof until the earlier of (a) the date that is two years after the date hereof or (b) such earlier date, if any, as may be required by applicable law or regulation. The Policyowner and the Insured agree that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may be relied upon by the Life Insurance Company or any of its agents.

\_\_\_\_\_  
Signature of Policyowner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Policyowner's Social Security Number

(Include Second Policyowner if applicable)

\_\_\_\_\_  
Signature of 2nd Policyowner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
2nd Policyowner's Social Security Number