LIFE SETTLEMENT APPLICATION

A. PERSONAL INFORMATION - INSURED (PRINT OR TYPE)

Name of Insured:_____ Gender:_____

Date of Birth:_____ SSN: _____

Address:_____

City:_____State:_____ Zip: _____

Telephone Number:_____Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower):_____

If Married, Name of Spouse:_____Dependent Children? _____

Complete for Second Insured, if applicable.

Is the Second Insured deceased? _____

Name of Insured:_____ Gender:_____

Date of Birth:_____ SSN: _____

Address:_____

City:_____State:_____ Zip: _____

Telephone Number:_____Email Address: _____

Marital Status (Single/Never Married, Married, Divorced, Separated, Widow/Widower):_____

If Married, Name of Spouse:_____Dependent Children? _____

A. MEDICAL INFORMATION

Medical History Summary of Insured:

_____

_____

Primary Physician:_____Telephone number: _____

Specialist:_____Telephone number: _____

Specialist:_____Telephone number: _____

Complete for Second Insured, if applicable.

Medical History Summary of Insured:

_____

_____

Primary Physician:_____Telephone number: _____

Specialist:_____Telephone number: _____

Specialist:_____Telephone number: _____

For additional medical or physician information, please provide a supplementary page.

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B. LIFE INSURANCE INFORMATION

Insurance Company_____Policy Number _____

Face Amount:_____Date of Issue: _____

Policy Type (Term, UL, WL, SUL, SWL, VUL, Other): _____

Annual Premium Amount:_____Premium Due Date: _____

Last Premium Paid Date:_____Amount Paid: _____

Has the policy or any of the policy premiums been financed? _____

C. PERSONAL INFORMATION – OWNER

Is the Insured also the Owner? _____

Complete if Owner is an individual not also the Insured.

Name of Owner: _____

Authorized Representative (if business): _____

State of Formation (if business): _____

Relationship to Insured: _____

Date of Birth:_____SSN/TIN:_____

Address: _____

City:_____State:_____Zip Code: _____

Telephone Number:_____Email Address: _____

Has the Owner ever declared bankruptcy? _____

Is this policy being used to secure a support obligation (e.g. alimony/child support)? _____

D. D. PERSONAL INFORMATION – BENEFICIARY(IES)

Name of current Beneficiary: _____

_____

Relationship to Insured and Owner: _____

The undersigned represents to Abbistar that:

A. All the information contained herein is complete and accurate and may be relied upon by Abbistar ("ABS") and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives

B. The undersigned will immediately notify ABS of any material change in any information contained herein, occurring prior to conclusion of the proposed policy sale, including but not limited to: lapse, surrender or rescission of the policy, assignment of ownership or collateral assignment of the policy, and any change in beneficiary or creation of irrevocable beneficiary of the policy.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO APPLICANTS

Neither ABS nor its officers, directors, or principals provide legal, accounting, estate planning, tax or financial advice to prospective applicants regarding the advisability or relative merits of selling a life insurance policy.

An Owner must determine the benefits, detriments, risks and tax consequences of selling a life insurance policy solely in reliance upon the Owner's own attorney, accountant, or other appropriate professional advisors, only then, should a decision be made to sell a life insurance policy.

Owner has a clear and complete understanding of the current or future benefits of the life insurance policy being considered for sale. Each of the Owner and Insured(s) acknowledges that he/she has freely and voluntarily provided the information requested in this application.

The undersigned acknowledges they have read and fully understand this Life Settlement application.

OWNER/SELLER

Signature: _____

Printed Name: _____

Date: _____

OWNER/SELLER

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PERMISSION TO SHARE INFORMATION

Patient's Name *(please print)* :	Date of Birth:	Medical Record Number *(if known):*
Address:	Telephone Number:	Social Security Number:

Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From / Between (Circle):	**To / Between (Circle):**
Name:_____	Name:_____
Address: _____	Address: _____
_____	_____
Fax Number: _____	Fax Number: _____
Telephone Number: _____	Telephone Number: _____

I,_____***(Name of Individual)***, authorize disclosure of my protected health information asdefined 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, Pharmacy Benefit Manager, any other type of health care provider, and any other person, company or institution (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 photo static 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 Abbistar ("ABS"), Life Settlement Hub LLC (processor), any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for 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 information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION, Page 2

4. Purpose of Disclosure: 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 and life expectancy in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my life, health or medical status and condition in connection with any life insurance policy under which my life is insured.

5. Expiration: I understand this authorization will remain until the later of two (2) years after the date of my signature below or one (1) year after the date of my death.

6. 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; or by notifying Abbistar in writing, addressed as set forth below. Notices shall be deemed given as of the date received or on the date shown on the receipt or confirmation therefor.

Records Mailing Address: Abbistar, 69-09 164th St #201, Fresh Meadows, NY 11365

7. 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.

PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Date: _____

PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Relationship to Patient: _____

_____

Date: _____

(For example: Power of Attorney, Guardian ad Litem or similar status. Please attach a copy any official document confirming this status.)



LIFE INSURANCE INFORMATION RELEASE FORM

Policy Owner: _____

Insured: _____

Policy Number: _____

Insurance Carrier: _____

I hereby authorize my insurance company to furnish Abbistar and/or any of their affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, any and all information, verbal or written, including any life insurance policy illustrations, verifications of coverage, policy and application forms, riders or amendments related to the life insurance policy identified above.

I specifically authorize and request my life insurance company to rely upon a photo static or facsimile copy or other reproduction of this authorization as valid as the original authorization.

I agree and acknowledge this authorization shall remain valid for two (2) years after the date of my signature below.

POLICY OWNER

Signature: _____

Printed Name: _____

SSN/Tax ID: _____

Date: _____

POLICY OWNER

Signature: _____

Printed Name: _____

SSN/Tax ID: _____

Date: _____

DISCLOSURE

The owner of the life insurance policy that may be sold in a life settlement transaction, the Owner, should be aware of the following:

1. That there are possible alternatives to life settlement contracts for persons who have a catastrophic or life-threatening illness including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.
2. That proceeds of the life settlement could be taxable, and assistance should be sought by the Owner from a personal tax advisor.
3. That life settlement proceeds could be subject to the claims of creditors of the Owner.
4. That receipt of life settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government provided benefits or entitlements and advice should be obtained by the Owner from the appropriate government agencies.
5. That life settlement contracts entered into in certain states may contain an unconditional rescission provision which allows the Owner to rescind the contract within a specified number of days (usually either 15 or 30 days) after the Owner receives the life settlement proceeds, conditioned on the Owner's return of such proceeds and the Owner will consult with its life settlement broker as to the specific rescission period and requirements in the Owner's state of residency.
6. That the Owner has the right to know, upon request, the identity of any person who will receive or has received a commission or other form of compensation in respect of the Owner's life settlement transaction.

POLICY OWNER

Signature:_____

Printed Name: _____

Date: _____

POLICY OWNER

Signature:_____

Printed Name: _____

Date: _____

INSURED

Signature:_____

Printed Name: _____

Date: _____

INSURED

Signature:_____

Printed Name: _____

Date:_____

This signature page may be duplicated if there are more than two (2) policy owners.

AUTHORIZATION OF POLICYHOLDER AND INSURED
FOR USE AND DISCLOSURE OF NON-PUBLIC PERSONAL INFORMATION
FOR EFFECTUATION OF A LIFE SETTLEMENT TRANSACTION

In order to effect a potential life settlement contract for Life Insurance Policy Number _____ owned by _____ ("Policyholder") insuring the life of _____ ("Insured") (the "Policy"), each of the undersigned Policyholder and Insured hereby irrevocably authorizes Abbistar and any of their respective affiliates and any of their respective directors, officers, managers employees, agents and successors and assigns (collectively, the "ABS Parties") to use, and to deliver, disclose, give, provide and release, any and all information, including without limitation, non-public personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of or insured under the Policy, that any of the ABS Parties obtain, whether from the Policyholder or the Insured, any of their agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source, to any (1) life settlement provider and its employees, agents and representatives and their respective successors and assigns (collectively, a "Life Settlement Provider") or (2) any other person or entity that can under applicable law purchase the Policy without being a licensed life settlement provider, as may be necessary to effect a life settlement of the Policy.

Further, each of the undersigned hereby irrevocably authorizes each Life Settlement Provider to use and deliver, disclose, give, provide and release, any and all information, including, without limitation, nonpublic personal financial and health and medical information about the Policyholder and the Insured, including their identities as the owner of and insured under the Policy, that such Life Settlement Provider may obtain from any of the ABS Parties, to any financing entity, investor customer or any financing source of such Life Settlement Provider as may be necessary to effect a life settlement of the Policy.

Each of the undersigned hereby agrees and irrevocably consents that this Authorization shall be effective from the date hereof until two (2) years after the date hereof. Each of the undersigned hereby agrees that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may be relied upon by any person or entity.

POLICY OWNER

Signature: _____

Printed Name: _____

Title: _____

Date: _____

POLICY OWNER

Signature: _____

Printed Name: _____

Title: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Title: _____

Date: _____

INSURED

Signature: _____

Printed Name: _____

Title: _____

Date: _____

This signature page may be duplicated if there are more than two (2) policy owners.