2101 Park Center Drive, Suite 170
Orlando, Florida 32835
Office: (800) 561-4148
Fax: (407) 455-7765
abacuslife.com
email@abacuslife.com

ABACUS LIFE
OPTIONS FOR YOUR LIFE INSURANCE

Instructions: In order to provide you with an offer or determine if you qualify for one of our settlement options, Abacus Life will need to obtain some basic medical information on the insured and life insurance policy information from the life insurance company. We will either do a medical review call or request a copy of the insured's medical records from the insured's primary care physician. We will also request policy information like future premium requirements from the life insurance company.

The following 3 simple documents will give us authorization to go request this information.

Document 1: ***Life Settlement Questionnaire***

Please complete the 1 page questionnaire to the best of your ability. Leave blank anything you do not know or are uncomfortable providing.

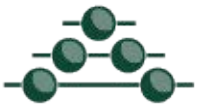
Document 2: ***Authorization for the Disclosure of Protected Health Information. HIPAA Compliant***

This form gives us the authority to do a medical interview over the phone and when needed gives us the authority to order medical records. Please be sure to fill in only **the insured's** information and signature.

Document 3: ***Life Insurance Information Release***

This form will be used to send to your life insurance company. This form will allow your insurance company to provide us with information about your policy including future premiums, loans, issue date, etc.…. Please be sure that only the policy owner signs this document. The policy owner is not always the same as the insured such as when a policy is trust owned in which case the trustee is the policy owner.

Please return these completed documents either by **fax (407) 455-7765** or by email **cases@abacuslife.com** if possible. If you need to use regular mail, please call us to assist you with a fed ex pickup service. Please call us with any questions or concerns.



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Life Settlement Questionnaire

1. Name of First Insured: _____ DOB: _____ SS#: _____

2. Name of 2nd Insured (I/A): _____ DOB: _____ SS#: _____

3. Insured's Contact Number: _____ Insured's Email: _____

4. Insured's Address: _____

5. Policy Owner: _____ Policy Beneficiary: _____

6. Agent: _____

7. Insurance Carrier: _____ Ownership State (Trust Situs if Applicable): _____

8. Policy Number: _____ Face Value: _____ Issue Date: _____

9. Policy Type (Please Check One): Universal Life ☐ Whole Life ☐ Term ☐ Other: _____

10. Name of Primary Care Physician: _____

Phone: _____ Fax: _____

11. Name of Other Physician: _____

Phone: _____ Fax: _____

12. Name of Other Physician: _____

Phone: _____ Fax: _____

13. Any Additional Doctor(s) and contact info

_____

_____

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Medical Questionnaire

PERSONAL DATA: (PLEASE COMPLETE FOR EACH INSURED)

1. Height: ____ ft ____ in Weight: _____ lbs. DOB:
2. Are you currently employed? If so, what do you do? _____
3. Are you currently married? _____
4. Have you previously been married? _____ Are you a widow? _____
5. Have you had any major life changes in the last 24 months? _____
6. Have you been hospitalized in the last 12 months?

_____
_____

7. Please describe your current living situation: ☐ With Spouse ☐ With Family ☐ Alone ☐ Assisted Living ☐ Hospice Other:

LIFESTYLE:

1. Do you currently, or have you ever smoked cigarettes? If Yes, how much? _____
   When did you last smoke? _____
2. Do you currently drink Alcohol? If so, What kind and how much? _____
3. How often do you exercise? ☐ Never ☐ Once a week ☐ 2-4 days per week ☐ More than 4 days a week
4. Do you participate in social activities outside the home? If yes, what do you do? ☐ Church ☐ Volunteer ☐ Travel ☐ Social Events ☐ Gardening ☐ Golf ☐ Reading

Medical:

1. Have you ever consulted a doctor, been treated for and/or been diagnosed with any of the following conditions?

(Please check all that apply)

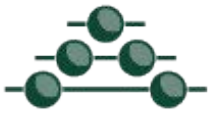
- ☐ Arthritis
- ☐ Alcohol/Substance Abuse ALS
- ☐ Alzheimer's Disease Anemia
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐
- ☐
- ☐ Coronary Artery Disease
- ☐ Cardiac Arrhythmia
- ☐ Cardiovascular Disease
- ☐ Chron's Disease Dementia
- ☐ Diabetes
- ☐ Hepatitis
- ☐
- ☐ HIV/AIDS Hypertension
- ☐ Hyperlipidemia Kidney
- ☐ Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Neurological Problems
- ☐
- ☐ Parkinson's Disease
- ☐ Pulmonary Disease
- ☐ Sleep Apnea Stroke/
- ☐ TIA

Please provide details on the above checked conditions:

_____
_____
_____
_____

Please list your current medications/dosages as they pertain to the conditions above:

_____
_____
_____
_____



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LIFE INSURANCE INFORMATION RELEASE FORM

I hereby authorize the issuer of life insurance policy number _____, owned by _____, and insuring the life of _____, to release to Abacus Life, and/or its agents, successors, assignees and affiliates, and their authorized representatives, any and all information concerning the above policy (including any conversions thereof or replacements therefore). This includes, but is not limited to, a complete copy of all policies and policy forms, master policies and certificates for any group policies, all applications, policy illustrations, verification of coverage forms, annual or periodic statements, premium information, change of ownership forms, change of beneficiary forms, and collateral and/or absolute assignment forms, as well as all other information reflecting ownership of and benefits payable under the policy, liens and assignments, premium waivers, and all provisions of the policy related to the foregoing. This Release shall be effective from the date of signature until the expiration of two (2) years following the death of the Insured(s). However, if any governing law or regulation limits this authorization to a shorter period of time, then this Release shall remain in force for the maximum period of time allowed by law. I understand and agree that I may be asked to renew this authorization as necessary by Abacus Life, and/or its agents, successors, assignees and affiliates, and their authorized representatives. I agree that any copy or facsimile of this Release shall be as valid as the original. This Release may be signed in counterparts if required to complete execution. This Release is effective as to each Insured and each Policy Owner immediately upon witnessing of such individual's signature, and is not conditioned upon signature by other insureds or policy owners. It shall be sufficient that the signature on behalf of each party appear on one or more such counterparts. However, witnesses must sign the same sheet at the same time as signature of the person whose signature is being witnessed.

x_____ _____

Policy Owner Signature or Trustee Date

_____ _____

Type or Print Name of Signatory SS# or Fed ID #

_____

Type or Print Name of Owner

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Authorization for the Disclosure of Protected Health Information
HIPAA-Compliant

Insured/Patient : _____

Date of Birth : _____

Social Security Number : _____

Policy Number : _____

Insurer : _____

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

Classes of Persons Authorized to Disclose My Protected Health Information: I hereby authorize each physician, doctor, physician practice group, nurse, hospital, medical facility, pharmacy, pharmacy benefits manager, any health care provider, any other person/entity in possession of my medical/health information and any party issuing or having access to my death certificate after my demise (each considered an "Authorized Discloser") to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this authorization. This authorization terminates any agreement I may have made with my health care provider(s) to restrict my PHI and I instruct my provider(s) to release and disclose my entire medical record without restriction.

Classes of Person Authorized to Receive My Protected Health Information: I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to any of the following persons or entities (each, an "Authorized Recipient"): (a) Abacus Life ("Viatical Settlement Provider"), (b) any entity/person with whom Viatical Settlement Provider has a contract, directly or indirectly, for services, which may include, but shall not be limited to, a life expectancy evaluator, tracking or monitoring service, records retrieval service and/or escrow agent, (b) any viatical/life settlement broker relative to a life insurance policy insuring the undersigned's life, (c) any insurance company that has issued a life insurance policy insuring the undersigned's life, (d) any shareholder, owner, partner, manager or member, director, officer, agent, advisor, employee or representative of an Authorized Recipient, (e) any entity/person who may seek to purchase an in-force life insurance policy which insures the undersigned's life or who currently owns a life insurance policy insuring the undersigned's life and (f) any and all respective successors and assigns of an Authorized Recipient.

Description of Protected Health Information Authorized for Disclosure and the Purpose for Such Disclosure: This authorization shall apply to any and all of my PHI, including but not limited to, medical records, x-ray reports, charts, laboratory reports, test results, prescription medicine information, or similar information or knowledge of me or my health condition, including but not limited to, PHI relating to AIDS/ ARC/HIV, alcohol and/or drug abuse, mental health issues andcommunicable diseases, whether or not personally identifiable or protected under any federal or state confidentiality or privacy law or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient to: (1) analyze, assess, evaluate or underwrite my health status, medical condition or life expectancy or to allow for the analysis, assessment, evaluation or underwriting of my health status, medical condition or life expectancy in connection with all aspects of a viatical/life settlement transaction, and, (2) to verify, monitor or update my PHI through a process known as "tracking" or "monitoring" of my health, medical status, or life activities should the Authorized Recipient be retained to perform such activities.

Expiration and Right to Revoke Authorization: This authorization shall remain valid until, and shall expire, one (1) year after the date of my death. I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser provided any revocation of this authorization, shall not apply to the extent that an Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation**.**

Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization: I understand that no Authorized Discloser or other covered entity may condition my treatment, payment, enrolment, 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 re-disclosure 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.

x_____ _____

Insured/Patient's Signature Date

*Abacus Life is a DBA of Abacus Settlements, LLC.