MILESTONE
Managers & Providers
Pennsylvania Limited Liability Companies

Life Insurance Settlement Application

Personal Information

Name Insured:___________________________________ S.S.#____________________

Current Address: ____

Telephone Number: ________________________ Date of Birth: __________________

Marital Status: (Circle One) Single Married Divorced Widowed

Dependant Children: ___ Yes ___ No

List Names: ____

2nd Name Insured:_________________________________ S.S.# __________________

Current Address: ____

Telephone Number: ___________________________ Date of Birth: _______________

Marital Status: (Circle One) Single Married Divorced Widowed

Dependant Children: ___ No ___ Yes

List Names: ____

Have you claimed bankruptcy: ___ No ___ Yes – If yes, please attach all discharge documents

Policy Owner:____

Name of Trustee: ________________________________ S.S.#____________________

Current Address: ____

Daytime Telephone: ______________________ Eve. Telephone: __________________

Life Insurance Policy Information

Insurance Company Name: ________________________ Policy Number: ___________

Date of issue: ___________________________________ Face Amount: _____________

Annual Premium: $_________ Last Payment Date:_________ Next Payment Date:_____

Loan Amount: $___________________ Current Surrender Amount: $_______________

Type of Policy: (Circle One) Term Whole Life Universal Life Group

Reason for Selling Policy: ____

Medical History

Insured's Primary Physician: ____

Address: ____

Telephone: ___________________________ Fax: ________________________

Insured's Specialist Physician: ____

Address: ____

Telephone: _________________________ Fax: __________________________

Insured's Specialist Physician #2: ______________________________________

Address: ____

Telephone: _________________________ Fax: __________________________

Describe Medical Condition:____

____

Notice of Disclosure

See the **Information Booklet**, attached hereto and made a part hereof, for information on life settlement transactions. All information disclosed above will be kept confidential as required by law. See **Covenant of Confidentiality**, attached hereto and made a part hereof. You have legal rights as a policy owner, and you may experience certain legal and tax consequences resulting from the sale of a life insurance policy. See **Disclosures To Owners of Life Insurance Policies**, attached hereto and made a part hereof. There may be possible alternatives to selling your life insurance. You are advised to consult a financial advisor, certified public accountant or an attorney regarding these potential alternatives. You are advised by us to seek the advice of your certified financial planner, your certified public accountant or professional tax advisor, and your insurance agent regarding this matter. If Milestone Providers LLC makes an offer to purchase your life insurance policy, you are advised to refer to the **Viatical Settlement Contract** supplied by the Milestone Providers, LLC regarding this transaction.

Terms and Conditions

Policy Owner acknowledges receipt of the **Information Booklet** , the **Disclosures To Owners of Life Insurance Policies**, and the **Covenant of Confidentiality**. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison. The applicant warrants and represents that all information contained in this application is true and correct to the best of his/her knowledge.

_______________________________________ _____________________

POLICY OWNER SIGNATURE DATE

_______________________________________ _____________________

POLICY OWNER PRINTED NAME DATE

_______________________________________ _____________________

WITNESS SIGNATURE (Cannot have a financial interest in the policy to be viaticated, or the viatical settlement contract) DATE

NOTARY

State of ________________________)
County of ______________________)

Subscribed to and affirmed before me this _______ day of ________ 20___.

(SEAL)

____
(Signature of Notary Public)

My Commission Expires: _____________________________

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Applicant Information

Complete Name (Please Print Clearly)

Address

City, State, Zip

Telephone Number (Include Area Code)

Date of Birth Social Security Number

Medical Records Request Information

Physician's Complete Name (Please Print Clearly)

Address

City, State, Zip

Telephone Number (Include Area Code)

Last Appointment Reason for Visit

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use and disclosure of health information about me as described herein.
Health Information to be Used or Disclosed: This authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.
Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: Milestone Providers, LLC; its insurance support organizations; its affiliates, providers, and reinsurers. A copy of my application may also be attached to any policy of a co applicant who is issued coverage as a result of the same application.
Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; re-insurers; consumer reporting agencies; insurance support organizations.
Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; and determine premium amounts.
Statements of Understanding: I understand that (1) I will receive a copy of this authorization; and that a copy of it is as valid as the original; (2) this authorization will be valid for 24 months from the date signed; (3) if I do not sign this authorization, or revoke it by writing to Milestone Providers, the Company may decline my application; (4) if I revoke this authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be re-disclosed only in accordance with applicable laws or regulations. I agree that this authorization will be valid for 24 months from the date signed, and know that my authorized representative or I may have a photocopy of it.
I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I agree that a photographic copy of this facsimile of this authorization shall be valid as the original. I agree that this authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absence any provision of any applicable state statute or regulation to the contrary, and which event it shall remain valid for the maximum period permitted hereunder.

Insured Signature Date

Print Name

Witness Signature Date

Print Name

Owner Signature Date

Print Name

Witness Signature Date

Print Name