COVENTRY FIRST
REDEFINING INSURANCE®

LIFE SETTLEMENT QUESTIONNAIRE

(please print clearly)

Life Insurance Policy Information

insurance company | policy number | issue date *(00/00/0000)*

face amount | total policy loan | cash surrender value

annual premium payment | next premium due date *(00/00/0000)*

last premium paid date *(00/00/0000)* | amount paid

Are there any liens against the policy? ☐ yes ☐ no *(if yes, explain)*____

Premium frequency ☐ annually ☐ semi-annually ☐ quarterly ☐ monthly

Type of policy ☐ term ☐ ul ☐ wl ☐ sul ☐ swl ☐ vul ☐ other *(please specify)*____________________

Policyowner(s)

name of policyowner(s) | date(s) of birth *(00/00/0000)*

driver's license number(s) | social security or tax id number(s) *(000-00-0000)*

name of president *(if corporate owned)* | name of corporate secretary

name of trustee(s) *(if trust owned)* | date of trust *(00/00/0000)*

daytime telephone number *(000-000-0000)* | evening telephone number *(000-000-0000)*

address

city | state | zip

If there are multiple owners, please attach an additional page including full name of owner(s), date of birth, driver's license number, social security or tax id number, address, and telephone number with area code. If more than one policy is being submitted, please attach an additional page including policyowner(s) and life insurance policy information as requested above.

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Names and ages of children, designated heirs and other dependents *(if none, state "None")*

____

____

____

Have you been party to a bankruptcy since the policy issue date? ☐ yes ☐ no

Marital status ☐ single ☐ married ☐ divorced ☐ legally separated ☐ widowed

Is the policy subject to liens? ☐ yes ☐ no

Are you a U.S. citizen? ☐ yes ☐ no *(if no, what country?)* ______________________

Are you the owner of any other in-force life insurance policies? ☐ yes ☐ no *(if yes, please list below)*

____
insurance company | face value

____
insurance company | face value

Insured Data

Purpose of transaction ____

Do you have any other life insurance policies in-force? ☐ yes ☐ no *(if yes, please list below)*

____
company | face value

____
company | face value

____
company | face value

First insured *(if joint policy, see second insured)*

____
name | date of birth *(00/00/0000)* | sex

____
social security number *(000-00-0000)* | driver's license number

____
daytime telephone number *(000-000-0000)* | evening telephone number *(000-000-0000)*

____
address

____
city | state | zip

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Are you a U.S. citizen? ☐ yes ☐ no *(if no, what country?)* ______________________________

First insured medical condition *(brief description)* ______________________________

____

Second insured *(if joint policy)*

name | date of birth *(00/00/0000)* | sex

social security number *(000-00-0000)* | driver's license number

daytime telephone number *(000-000-0000)* | evening telephone number *(000-000-0000)*

address

city | state | zip

Are you a U.S. citizen? ☐ yes ☐ no *(if no, what country?)* ______________________________

Second insured medical condition *(brief description)* ______________________________

____

Medical Information

First insured *(if joint policy, see second insured)*

name of primary physician | telephone *(000-000-0000)*

address

city | state | zip

name of specialist physician | specialty | telephone *(000-000-0000)*

address

city | state | zip

If there are any other physicians who have treated you in the last five years, please attach an additional page including full name of physician(s), specialty, address, and telephone number with area code.

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Second insured *(if joint policy)*

name of primary physician | telephone *(000-000-0000)*

address

city | state | zip

name of specialist physician | specialty | telephone *(000-000-0000)*

address

city | state | zip

If there are any other physicians who have treated you in the last five years, please attach an additional page including full name of physician(s), specialty, address, and telephone number with area code.

THE FOLLOWING WILL BE NEEDED TO OBTAIN AN OFFER:

- A copy of the insurance policy if available or a copy of the face page
- A current in-force illustration showing premiums necessary to carry policy to maturity
  - If Universal Life policy, show minimum premium payments
  - If Term policy, submit a current premium schedule and a conversion illustration to a Universal Life policy showing minimum premium payments
  - If Whole Life policy, run a vanishing premium illustration
- Medical records for the last five years including family history *(Coventry can obtain records with an authorization)*
- Authorizations to release medical records and policy information
- If policyowner has ever been bankrupt, include a copy of the bankruptcy discharge
- If policyowner has ever been divorced, include a copy of the divorce decree

In some cases the following may be requested: updated medical records, doctors' notes, test results or alternate illustrations.

signature of insured | date *(00/00/0000)*

signature of insured | date *(00/00/0000)*

signature of policyowner | date *(00/00/0000)*

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AUTHORIZATION

(please include this authorization to release medical and policy information with your application)

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefits manager, hospital, clinic and/or any other healthcare provider identified below (each, an "Authorized Discloser") to provide Coventry First LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("Coventry"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Coventry the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Coventry in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Coventry with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions or replacements).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser or Coventry 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, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a healthcare provider, healthcare 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, any of my medical information disclosed by any Authorized Discloser to Coventry may be redisclosed by Coventry and 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 I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

Authorized disclosers: ____

____

____

____

name of insured | signature of insured | date *(00/00/0000)*

____

date of birth *(00/00/0000)* | social security number *(000-00-0000)*

____

name of witness | signature of witness | date *(00/00/0000)*

____

name of owner *(if other than insured)* | signature of owner *(if other than insured)* | date *(00/00/0000)*

____

name of witness | signature of witness | date *(00/00/0000)*

This application may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.

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