EXHIBIT 5

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LISA Fireside Chat with Alan H. Buerger and S. Jay Olshansky
October 24, 2024
Moderated by Adam Belinsky

Adam: As you just heard, this session is going to focus on LEs and what I guess I'd call a bit of a dispute, highlighted by Coventry's press release informing the market that based on their data, Lapetus LEs have been materially and consistently shorter than other LEs in the market. And in turn, Lapetus' response in their press release, which focused on their performance data, highlighted a 96.5% accuracy rate based on their data. Understanding this issue is critical for people involved in this industry because obviously, life expectancy is material input to how we value policies, build portfolios, and look at expected cash flows.

I'm going to briefly introduce Alan and Jay. I think you can all read the more detailed and extensive bios that are in the materials. So, Dr. Jay Olshansky is the co-founder and chief scientist at Lapetus Solutions and professor of public health at the University of Illinois of Chicago. The focus of Jay's research is on estimates of the upper limits to human longevity, exploring the health and public policy implications associated with individual and population aging, and his expertise is in human longevity.

Alan Buerger is the executive chairman and co-founder of Coventry. He's an expert on the convergence of life insurance and capital markets and has been a strong voice for the life settlement industry over the years. Under Alan's leadership, Coventry has enabled policy owners to receive more than $5.7 billion for their unwanted policies. Alan's a former chairman of LISA and is a frequent keynote speaker on different topics at these conferences and other conferences. So, the format this morning is that Alan is going to present for about 15 minutes first, and then Jay has 15 minutes, and then the idea was for it to be more interactive, which was to get questions from the audience.

A number of questions have been submitted previously, but there's probably time for some additional ones as well. So, we'll look to those. And with that, I'd like to start.

Please come up.

Alan: Good morning.

When Jay and I and Bryan first talked, I said to him, given that I'm responsible for some of the controversy, that the format should be up to him, and so that's why I'm speaking first. Jay suggested that would be an appropriate way to begin.

I've learned a lot in preparing for this morning's Chat. for example, if you ever see a policy insuring a Greenland shark, don't buy it. A

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Greenland shark, I learned from YouTube from Jay, has a 500-year life expectancy. So, unless it's about 494 years old, I wouldn't touch it.

But then again, their life insurance rates are probably very, very low.

Jay, to share this event, this chat with Jay, is daunting in many respects. He is truly a pioneer in the study of longevity. He's an accredited academic, a recognized, world-renowned academic and scientist, and has, I've learned, created and broken new ground in the study of longevity. It doesn't mean I agree with him. But just ten days ago, he was quoted on the front page of the New York Times with this recent paper that was published in Nature Magazine on the Implausibility of Radical Life Extension in Humans in the 21st Century.

And everything he says makes a lot of sense. Another way, if I get it right, that Jay would say is (pause) we should be focusing on the quality and the health of our life in our later years, not extending the later years because future increases in longevity are unlikely to be material. So, what we should focus on is being healthy in those later years.

And it makes a lot of sense. And as I said, he's prolific. He knows how to get his message out there.

He's uncommonly articulate, having listened to many YouTube videos. And he's an outstanding salesman for his ideas.

He's also wrong.

Now, I don't expect to change Jay's mind. I've listened to enough of his YouTube videos, and we've had multiple conversations now. And he has his convictions.

As you all well know me, I have mine. But let's see where we can go. One book that I recommend, and maybe as a door prize for a couple of you, I'll give them out.

If you saw that you (Jay) had a few sales this past week on Amazon, they were me. It's ''The Rise of the Generians'', where unlike everything else I read of Jay's or YouTube videos I saw, he addressed the life-settlement business. And his view, although frankly I didn't understand it all, his view of longevity in our industry.

So, we (Coventry) did the study. And then when it was questioned, we had outside actuaries, two professors, led by Dani Bauer, who's a professor in the actuarial department of the University of Wisconsin. He's published many papers on life settlements.

In the actuary, he published a paper with Mike Fasano. He, too, is

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well-credentialed. He, too, is an academic and someone I've come to respect.

And he peer-reviewed our work. Now, I'll quickly say, not peer-reviewed in the context that Jay thinks of in terms of published journals, but peer-reviewed, did we do our work, did we do it accurately? And they agreed with our assessment.

And it was, very simply, to repeat quickly, Lapetus is, and this is based on 4,000 life expectancies. Lapetus is, on average, when paired with other underwriters, LEs on the same life, on average (are) 31 months shorter, 85% of the time. Now, to put that in perspective, the other providers (were on) average being shorter, less than 10% of the time, when we paired them against their peers.

So, 85% of the time is an extraordinary number. When we took out the average, because that meant 15% of the time, Lapetus was longer. So, when we took out those, figuring that isn't what would be applied, the average was then 40 months shorter on those, on the 85% where they're shorter.

That's unsustainable. I'll have more on that, perhaps, in the Q&A. But I only see a couple results from today.

The first is Jay will convince me and you (the audience) that our portfolios are worth a hell of a lot more than we believe they are. And we'll all walk out of this room really happy. In our case, we believe our portfolio would be worth double.

And we own $2 billion of life insurance, so I like that notion. The other possible result today is people will realize that as credentialed, as Jay and Carl are, in the field of, you can nitpick this, the population-level mortality, not life-settlement mortality, then people will say, no, I'm not richer today. And yeah, the 25 years of experience that we've seen in our industry wasn't substantially better by 50 to 100%.

In fact, it was not very good for too many investors. Now, we've had very cordial conversations. I have come to respect Jay, even though I disagree with him.

But since we put out our press release and then the following release, Professor Bauer's analysis of our work, what I haven't heard from Lapetus is we're wrong about the fact that they're shorter. We're right or wrong about our conclusion. But I haven't heard, no, we're not shorter.

In fact, without quantifying it, what I've heard is we know we're shorter. Is that fair? (Jay disagreed.) Okay, well then, you're done.

You'll be here in a minute. I thought I heard you say we understand we're shorter. But that's why we're having a chat.

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I looked at the Lapetus website, and I have a few bones to pick with you (Jay). You say, "the unique method provides a greater level of insight and an actual-to-expect ratio of over 96%." That's not true.

It may have been true in November of '21 when you filed to Florida. It may have been true. I'll put my skepticism aside.

But it's not true today. And in your book, "The Rise of the Generians", you say, and I'd like to understand this, that you "adjust your actual-to-expected in real time." You also say, and this I really didn't understand, and I think all of us would benefit from understanding, that using VBT, or some variation of VBT, as opposed to a general population data, which is the crux of our disagreement, that "using VBT would be double-counting."

And I think I know, well, I know I've articulated that correctly. If not verbatim, I've articulated that correctly. And you said in the same paragraph, I'll have more on this later.

And I kept reading and reading, and although you did talk about it, I confess I'm not sufficiently an academic that I understood. So, I think we'd all benefit if you have an opportunity to explain that. But to go back to the actual-to-expected, we did an actual-to-expected based on our data, which is obviously incomplete.

And for three durations, we come up with 60% actual-to-expected. And we've been doing this for 25 years. Now, that doesn't include an IBNR, although we're very good with all the various things that we do as a company in finding deaths.

We've helped more than one LE provider in finding deaths that they hadn't found. So even if you said the 60 was 10% more 66, it's not good. So, I appreciate this opportunity.

I still have a minute and a half. So, I'm going to end early, and I'll end with this. I'll take the second pill.

And that's up to Jay to explain it to you. Thanks very much, everybody.

Jay: All right, thank you very much, Alan.

Actually, I really appreciate it. I think for the folks listening, it's really important and useful to have these kinds of open discussions. We do this all the time.

We love this. This is perfect. And so, you know, greatly appreciated your discussion.

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There's lots to talk about. These are some of the issues that I'm going to deal with. And I put my email address up there, and I will show a copy of the book.

And I actually have a few copies up here in front. And if anybody doesn't pick up a copy, this is sort of how we created our business, the work that we're doing for Life Settlements. Send us an email, and we'll send you a copy for free.

The part of what I'm going to talk about today is testimony that I gave before Congress two years ago about issues associated with aging and longevity. I just want you to be aware of that. So, these are the three topics that I'm going to address.

One is about this new paper that came out, because it just came out two weeks ago, and it is highly relevant to this industry. You need to know what our conclusions were and why we came to these conclusions. The second part, which is where I'll spend most of my time, addresses some of the things that Alan raised.

And then I am going to discuss at the end very briefly why it is that I believe we should be standardizing this industry as a way to make it grow. And I've got some very specific suggestions on how to do that. I think in the end, this is where I would like to see all of this discussion go, and that is improving the industry.

We're huge fans of this industry. We wouldn't be it otherwise. So let me start out with this question about living to 100.

Now, this is not a new question, for me anyway. It's an old question, and I first addressed this in our lead article in Science in 1990. And I've been working in this field for decades prior to the existence of the life-settlement industry, so I'm quite familiar with everything associated with aging, longevity, lifespan estimation, not just at the population level, but at the individual level.

Remember, I'm a professor of public health. In public health, it's all about individuals. We use population data to inform what's going on at the individual level.

We use individual-level data to inform what's going on at the population level. In this piece, in 1990, we estimated how long humans can live. We said it's about 85 years on average, about 88 for women, and 82 for men.

It was a hypothesis. I'll explain why in a minute. This is the new data that just came out two weeks ago, and the evidence is no longer hypothetical.

It is definitive. And I'll show you what this is briefly and why it's relevant. This is the image I like to use to illustrate what this is all

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about.

This is a distribution of death. I know we have actuaries in the room. This is the DX column of the life table for non-actuaries.

This is what death looks like for a population. In 1900, it's the black line. 2016, the blue line.

And the red zone there is designed to represent the high risk of death from aging-related causes of death from senescence itself. Now, what we argued, and we argued way back then, was that there's going to be a slowdown in (extension of) life expectancy beginning in the 21st century. A lot of people disagreed with us.

Advances in medical technology will accelerate. We said no. Well, they will accelerate, but it's not going to lead to a dramatic increase in life expectancy.

That blue line right there is something that you will see everywhere in the world. Every country in the world, certainly all developed countries, and even within subgroups of the U.S. population or any population, including insured populations, that is exactly what it looks like with minor variations on a theme. So, we said there will be a slowdown.

As life expectancy goes up, the rise in longevity must slow down. This is no longer a hypothesis. It has now been demonstrated definitively in our original science article.

In a subsequent science article in 2001, we found the same thing in Japan, France, and the United States, and now we've seen it in all long-lived countries. This is no longer a question of whether this is happening. It is happening to all of us.

And last, but not least, mortality improvement factors, which are part of this industry and are part of VBT tables, are overestimating survival. This isn't a hypothesis anymore. Somebody's using a 1% to 2% annual improvement in total mortality.

They will be overestimating survival. Going forward. So, you should be aware of that. Read the papers. The evidence is powerful. This is what the data looks like.

This is just figure one from there, but I do want to point your attention to the green line. This is the annual improvement in life expectancy by country. You'll see a pretty dramatic slowdown.

Certainly, in the United States, and of course since most everyone here is dealing with people from the United States, you need to be aware that mortality improvement in older individuals in the United States has slowed to a trickle. Now, insured populations are a little bit

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different. They're doing a little bit better than the rest of the population, but as it turns out, the mortality distribution for insured populations is exactly the same as all other humans.

It has never changed. You need to be aware of this. There's nothing particularly special about insured populations that we haven't seen with other subgroups of the population for the last 40 years that I've been doing work in this area, but you need to be aware of this.

By the way, you will notice that in any of these figures, any information I will show you, we put in the source. We not only tell you where we got the information from, but how we did what we did. So, what does this mean for life settlements?

Survival for age 100 is going to remain a rare event going forward. Do not expect a large number of centenarians, unless you're dealing with people that are 98, 99. Your probability of making it to 100 is higher than average, but overall, we're going to see a trickle of an increase in the percentage of the population that makes it out past 100.

The prevalence is going to go up, but that has to do with past trends. Infertility has got little or nothing to do with declining urban age mortality, so we will not see this dramatic increase in the number of centenarians. Mortality improvement factors in the 1% to 2% range, which is what we see frequently in various industries, including in especially insurance.

I've been advising multiple insurance companies over the years and the Social Security Administration on their forecasting assumptions. This will overestimate survival going forward. Life Settlement industry can remain confident in the constancy and stability of human longevity.

This is one of the reasons why I like this industry so much. It's basically a way of saying we know exactly what is going to happen to a cohort of lives that you are evaluating. We know what that distribution is going to look like.

Last but not least, and this is highly relevant, this new field of geroscience, which I'm just going to briefly show you in a video, is coming online. I'm heavily involved in this, and the reason I'm showing this to you is because my colleagues and I are involved in the development of new technology to slow biological aging in people. This means we have our finger on the pulse of developments that are happening.

I just want to show you one brief video.

[Video Narrator]: Section 7, Compression of Morbidity, Adding Life to Years. The concept of compression of morbidity, articulated by bio-gerontologist Jay Olshansky, posits that by delaying the onset of age-

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related diseases, we can shorten the period of illness and disability at the end of life. This concept aligns perfectly with the goals of geroscience, which seeks to extend health span and allow individuals to live longer, healthier lives.

By compressing morbidity, we can reduce the burden of age-related diseases on individuals, families, and healthcare systems. It would allow individuals to maintain their independence and quality of life for a longer time, leading to a more fulfilling and productive life.**[end of video]**

Jay: So, there will be breakthroughs that occur in the world of geroscience that allow us to slow aging. People in this room are going to benefit. People that we evaluate in the life science world will benefit.

It is not likely to extend life very much, but it is likely to extend health span considerably. And as Alan pointed out, really that's the focus of what we should be doing, in my view. All right, so since we have access to all of our data, let's take a look at what our data actually show at Lapetus.

A lot of the information, as Alan pointed out, is contained in our book. I don't know how many other companies have written books about how they operate. We have.

You want to understand how we operate? It's all in there, in black and white, in the history of how we came into this business to begin with. Which, by the way, began with a keynote speech that I gave at a LISA conference years ago in Arizona.

So, let's take a look at some of the data. Here are the facts. We looked at over 15,000 cases, 11,000 unique cases.

This is highly relevant, especially to some of the issues that Alan was raising earlier. We've had about 800 unique maturations. I say unique for very specific reasons.

About 23.6% of our cases are duplicates, meaning we've evaluated the same person more than once, often for the same company, including Coventry. The percent of our maturations that occurred earlier than our point estimate? 94%.

Percent of our maturations that occurred later than our point estimate? 6%. Percent of cases reviewed now alive that were predicted to be alive? 98.7%. And you might be asking yourself, how is that possible? Why does this happen? The answer is surprisingly simple.

This is what our distribution looks like of the LEs in the Blacklist database. We've only been around for a few years. Guess what?

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The only thing you can see, and this is the answer to most of Alan's points that he was raising, the only thing you can see is the far-left side of the distribution. Anytime you can only see one tiny part of a distribution, you will come to a very specific conclusion, which makes sense if that's the only thing you're looking at. And, of course, that's the only thing that we have.

That yellow bar, by the way, is supposed to go all the way down to the bottom. For some reason, it didn't show up here. But that's the only part of the survival distribution you can see.

Now, we took a look at the data from Coventry. And here's what we found, as you indicated correctly, over 4,000 case reviews. The percentage of case reviews for Coventry that are duplicates, 9.7%. Why is this relevant? If you review the same person multiple times, you will come to different LEs, especially before or after a procedure that somebody is having, like an organ transplant of one kind or another. This can have a profound influence. So which case you evaluate is highly relevant.

200-plus unique maturations that we've seen in our Coventry evaluation. The percent of the maturations that occurred earlier than our point estimate, 95.5%. I'll pause for a second. Percent of maturations that occurred later than our point estimate, 4.5%.

Percent of cases reviewed now alive that were predicted to be alive, 99.1%. Those are the facts. No ambiguity. All right, so how would you create an apples-to-apples comparison? And my goodness, we would actually love to do this with you.

We'd love to work with you on this. We've offered to do this. But how would you do it if you were doing a legitimate apples-to-apples comparison between us and another LE company?

Well, all assessments must be clinical medical reviews because all of ours are clinical medical reviews. Medical records on the same patient must match perfectly. You must adjust the LEs to account for Lapetus interpolation of life tables.

If you're not familiar with how we operate, we don't use age at last birthday or, you know, however some actuaries deal with these particular issues. We actually use date of birth for precision. For a very specific reason, you must adjust accordingly.

Adjustment of the LEs to account for time passed between assessments. My goodness, this is so basic. We may do an assessment in January.

Somebody else may do an assessment in June. You can't just subtract six months. Life tables don't work that way.

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This is how you would do it if you were doing this legitimately. Lapetus generates multiple clinical reviews on the same patient. These are duplicates.

The choice of which one you use is highly relevant. You must make a decision. If I were doing this analysis, I actually would do it two ways, one using the most recent, one using the earliest to see if there's a difference between them.

But it would be a research study that we would do. Remember, we're scientists. We do this for a living. We love this. This is exactly how we operate. Last but not least, and this is also critically important, all published research in science must include a section on data and methods so the work can be replicated and validated by anyone.

The absence of this critical step generates an instant rejection and invalidates the science. I can't be any more unambiguous than that. Now, how do we operate?

100% of our reviews are medical. Most of our LEs are reviewed internally by PhDs with expertise in survival analysis. We're certified through the states of Florida and Texas, and we use the CER method, very simple and straightforward.

All of our reports, we provide a claim, an estimate, of how long we think an individual is likely to live. Remember, this is our expertise. We don't just give you a number.

We give you the empirical evidence to support it. It's in the report itself, and then we provide a justification or the reasoning behind it as well. There's no black box.

You know exactly what we concluded, how we concluded it, and why we concluded it. Should VBTs or related life tables be used when assessing survival in medical reviews? Absolutely not.
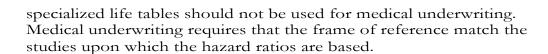
Why? So, for those of you who may not be familiar with how the world of public health operates, this is a typical hazard ratio, right, hazard ratio for smokers versus non-smokers. What does this mean?

When a hazard ratio is 1.9, it means if you're a smoker, your risk of death is 90% higher than if you're a non-smoker. It's not complicated. It's not rocket science.

The issue is that the frame of reference in the world of medicine is not a VBT table. The frame of reference in all of medical science is the baseline population. You should not be using anything other than a generic general population life table if you are doing a medical review.

If you don't, you are overestimating survival. So VBT or related

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specialized life tables should not be used for medical underwriting. Medical underwriting requires that the frame of reference match the studies upon which the hazard ratios are based.

Remember, this is what we do for a living. My original article on the relationship between obesity and mortality, which I published in 2005, illustrates this point perfectly. Using such tables would overestimate survival.

The data, I'm not going to spend a lot of time on this except to say we have access to all of the data, including over 8 billion people, the entire planet, which we evaluate on an annual basis, but we also have access to all of the clinical medical reviews, and we have access to endings, which serves as the basis for the relationship between all impairments and subsequent survival. There's an ending we don't have when it comes to data, including, by the way, a considerable amount of data from life settlements. How do we operate?

Very basic three determinants of survival. I'm almost done here. We look at primary impairments for individuals.

We look at the social determinants of health. These are in the reports. We actually offer genetic analysis, which nobody uses.

I'm a little surprised that nobody's using it, but you can actually... We look for a particular gene or set of genetic polymorphisms associated with exceptional longevity. If you carry this gene, this polymorphism, which I carry, I'm pretty sure Alan carries it as well, there's about a 50% elevated probability of surviving past the ages of 90 and 100 if you carry it.

Why the industry's not using that, we don't know, but we created it because that's what I would want to have if I were in your shoes. So, I'm going to move along. I think I've probably gone over my 15 minutes, haven't I?

I do lose track of time. Life settlement reports are a lot more than point estimates, a lot more than numbers, and we are, as best as we can, providing you with as much information as we can that is not quantifiable. And you'll see that in our reports in terms of survival skews.

We are experts on super-agers. We study them for a living. We give you signals as to whether or not individuals are potential super-agers.

And I'm going to end... I'm going to pass by this. And I'm going to end with this.

We believe that the industry would benefit tremendously from standardizing elements, which we would love to work with the other LE providers, everyone else in the industry. We think this would be

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extraordinarily valuable. Create a gold standard life table.

For those of you that were at my presentation, my very first LISA presentation, I recommended this then. A gold standard life table. It requires that we all work together and actually combine our data.

Just for the industry. Eliminate the wait for life table updates. My goodness, what are we doing?

Waiting for years for life table updates. We could create live life tables for the industry. We could see events happening in real time, including events like COVID and what their influence is on the population.

We should be constructing imperative-specific survival curves for the industry. This is doable. There's no reason why we can't combine our data to do this.

And last, but not least, standardize the calculation of metrics of success and accuracy. So, I'll stop there. I apologize if I went over.

There's a lot to talk about, and this is really a useful and important discussion that we're having, and I'm really appreciative of Alan and others for allowing this to happen.

Thank you.

Adam: Thank you for those comments. Very helpful. I got a lot of questions that came from people in the audience. They're all over the place.

But maybe, Jay, I can start with one question, which is, is the Lapetus a point estimate, or is it meant to be, the way we look at LEs, a point on the curve that approximately 50% of the people still are situated die by, and 50% survive? Because your report has a survival curve in it, which is what our industry uses to determine and calculate expected cash flow.

Jay: So, this is a complicated question. So yes, we do provide a point estimate. We do provide a range.

But the concept of a mean and a median has less meaning the older populations get. So, for younger individuals, yes, you can actually use the equivalent of a mean and a median, but at older ages, which is most of the data that we're looking at, and most of the information that comes in, a mean and a median does not have any significant meaning, and it shouldn't be used, in my view. So, there is a point estimate.

Look, let's be honest. We know in the world of public health and aging science that no one can predict precisely how long someone's

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gonna live. That can't happen.

It's never gonna happen, and we're never gonna be able to have any level of absolute precision. You may remember years ago, I said, you take a population of 1,000 people, you evaluate how long they're gonna live, you're gonna be on target in a given year about 5% of the time. Yeah, roughly, depending on the age group that you're dealing with, yeah, roughly 48% are gonna die earlier, and 48% are gonna live longer, but that percentage distribution will vary depending on the age that you're dealing with.

So, it's not a simple answer to that question.

Adam: So, I think the question came to me was, do we have a disconnect in terms of how we actually price policies, how we use survival curves, and apply them to cash flows? Because that, fundamentally, your reports have survival curves just like every other LE provider, and we're pricing, if we take your report, we look at it and we generate what we think is expected mortality at different points in time.

And that's where things seem to be falling down.

Jay: So let me correct you. Our survival curves are not like other LE providers.

And let me tell you why, and why this is important and relevant in the industry. So I'll give you sort of one of our secret pieces of information on how we operate. The one thing that I pointed out early on was that the mortality distribution for humans has never changed.

And I've now demonstrated empirically in multiple articles that it's not gonna change in this century. What that means is that you have to retain the observed survival distribution in a population no matter where your point estimate is. The moment you violate that distribution of death, which is what happens when you use a plus minus system, if you haven't made adjustments accordingly, you come up with a skewed distribution of death that violates the basic biological principles of human survival.

So no, ours are not like other companies that are providing LE estimates. We use a vertical shift in the survival distribution. So if somebody is 60 years old, let's just say they're 70 years old, let's say this represents 70, and we come to the conclusion that biologically they may be 75, for example, you would retain the remaining survival distribution for an average 75-year-old in the population. The moment you don't do that, it would violate the basic principles of human biology.

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Adam: So, Alan, where do you think this is going?

Alan: Well, can we go back, can you put up for everybody, Jay, the slide with the four statistics?

That it's the slide that shows of the 4,000 cases that you've done for Coventry, what the actual deaths (were), and you have three other stats on that slide. It's up in the there.

Hold on, no, it's right here.

Jay: Oh, you're gonna do it.

Adam: It's up there, but it's not here. Oh. That's the problem. There we go. It's not over there.

Alan: It's back about five or six, if I remember correctly. It's four data points. You're close. Wait, that's it. Go back. Forward.There should be four all together.

In our first conversation, you made the point you're very data-driven, and you're a scientist. And you and Carl said, you're academics.

Jay: Sometimes.

Alan: And you said in a YouTube speech, the science, you're referring to the facial analytics, to be clear. "The science is ironclad."

Jay: Which science?

Alan: You were referring to the facial analytics. It's a YouTube, it's online. I can point it out to anyone. That, to me, is an oxymoron. Science is not ironclad.

Science is about this data. And there's a different slide, but I'll talk about it. These may all be correct, and I'm sure they are, but they don't have any meaning, for example.

Just for perspective, you talked about the different times LEs are done. In our study, and I'm sure you recall, we said, and we made a point of this, that we only compared LEs that were done within 90 days of one another. Well, you can say so, and I'll let the audience make their own judgment.

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We didn't take LEs that were at disparate times. We took LEs that were ordered at essentially the same time with the same medical files. The percentage of maturations that occurred earlier than the point estimate would be expected if you were routinely too short.

You'd expect that to be the result. And the fact that the percentages that occurred later than the data point also has no meaning because, in your own words, you don't have enough experience, so that has no relevance whatsoever. But we have the slide where you said, we looked at Coventry's data, and you had 4,000 deaths.

Or, I'm sorry, 4,000 cases, 200 deaths, right? We agree with you. We did that same analysis, but we did one more analysis.

We expected 330, and that's the crux of it. Now, we can quibble with, how did we arrive at our Expected? What's the shape of the curve?

But we're not gonna quibble to the extent of 65%, saying, so we thought we'd have 65% more deaths. This is three durations, okay? It's where all the, and in fact, with the five durations that we have, it's 209 deaths.

So, we can quibble with that. We can quibble with our methodology. We can say, eh, you shouldn't have used that curve.

You should have had, your expectation should have been different. So, instead of 330, it should have been 260? Where's the flaw in my logic?

Jay: You know what we would love to have done? And all you had to do was ask us. We would have loved to have sat down and worked out the details and addressed all of the issues that were raised here.

But you didn't do that. Now, we're here. We're always here.

We always meet with our clients as often as we can to address any questions or concerns that individuals have. We actually go to our clients and ask for recommendations on how we can improve what we do. Can we provide you with additional information?

You may notice that every year, we change and add additional information to our reports. The best thing that we could do, and we'd be happy to do this going forward, we'd be happy to sit down with you and do a detailed analysis that goes through all of the issues that we raised here. And why don't we work it out together?

Alan: I'm happy to do that. I think your reports, I don't think there's anybody that provides better reports than you. I think they're

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outstanding.

But the fundamental disconnect is, and I still don't understand it, is your view that you're double-counting. Because it's inconsistent with your prior statements.

The Actuarial Standards Board says in 3.31 of their promulgation number 48 that "the actuary should use a base table, that in the actuary's professional judgment reflects the characteristics of the underlying population." And, you've said in multiple papers and in YouTube presentations, in fact, one of the things that left the biggest impression on me is you described Chicago and how you can walk across the street from one neighborhood to another and have a 15-year differential in life expectancy. That's a general population. That's not an insured population.

So, I don't understand, I really don't. And I think we'd all benefit if we could understand how you can use a general population table that includes all the neighborhoods in Chicago and Philadelphia and elsewhere and in Appalachia and people who don't have as you so articulate, so well articulate that affluent people, people with higher education, people with access to healthcare, it's all spelled out in your book, it's really articulate, it's really well laid out. How can you then use a general population table to determine life expectancy of the people that is our population?

And if we can cross that bridge, we can work together.

Jay: I think we can.

Adam: Before you answer that, I just want to point out of all the questions I got from actuaries, that was the number one question.

They know there's hundreds of tables done by the side of actuaries for all different populations. The VBT table has hundreds of thousands of insured lives, insured lives, and these, in their estimate, are different because of the factors Alan said and the fact that they've been screened out by life insurance companies. How do you go back to general population?

That was the question I got the most from, I'll say the actuaries, and then I'll tell you the other question that I got the most, which has to do with actual performance in real life.

Jay: Yeah, so, I mean, I believe I answered that already, and I'd be happy to sit down and discuss it in great detail, but the answer is really straightforward. When you have an impairment of one kind or another, and you're trying to figure out how that influences the

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survival of an individual, let's say you have prostate cancer.

That's probably not a good example because most people with prostate cancer survive, but some particular type of cancer or cardiovascular disease, and you wanna know how long you're gonna live. You go to your doctor, your doctor goes to the medical literature. By the way, we write much of that medical literature ourselves, our team, so we're part of that.

The frame of reference is not an insured population. The 1.0 in the hazard ratio is a general population. If you use a VBT, you elevate the base.

This is what I mean by double counting. You can use a VBT appropriately for non-medical reviews. You still have to make an adjustment of one kind or another, but if you don't make an adjustment, that's probably why you're getting the numbers you were getting, but I think if we sit down and work it out together, I think we can come to a fairly straightforward solution, but there actually is one thing that I wanna show you.

Can I actually have the, so I pretty much anticipated you coming up with this question, and I just wanted to show you something that is put out by the Society of Actuaries that I think in part addresses this. I left it in there just in case this question came up. So this actually is an old age mortality experience study report from the Society of Actuaries, and it shows you what the distribution of death looks like for an insured versus a general US population.

For those of you who may not be able to see this very well, this is females 79 to 90, males 79 to 90, and 65 to 120. What do you see? A virtually identical mortality distribution for insured populations versus general populations.

You will see the mortality rates a bit lower for insured populations, but guess what? We've been studying the equivalent of insured populations for decades prior to the existence of the life settlement industry, and it's easy to simulate an insured population. All you have to do is pick one variable and one variable only.

We were discussing this over breakfast with somebody.

It's education.

Adam: I'd like to get some questions from the audience, but before we do that, the number one question I got from everybody, or not everybody, the number one question I got from investors, if the life expectancies are too conservative from the LE providers, and Lapetus LEs are more accurate, but on average seem to be shorter, why aren't the portfolios (unclear) They should be performing at a level that is

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not happening from a financial point of view.

Jay: That's not really a question for me, is it?

Adam: It is.

Jay: Our job at Lapetus is singular. I think just like the other LE providers.

We do one thing and one thing only, which is provide the best estimate we can provide on how long we think someone is gonna live. How you use that information is up to you. There is an incredibly amount of rich information contained within our reports.

You said so yourself, that these reports are incredibly detailed. It is the maximum amount of information you could possibly get. You're getting all the information on the impairments.

You're getting all the information on the social determinants of health. If you ordered them, you would actually get the genetic analysis as well. Those are the three pillars of estimating duration of life.

We can't give you any more information than that. That is the maximum that can be received. Now, how you use that information is up to you, and the question you're asking is not to us.

It's to the people that are using the information that we're providing to you.

Adam: Well, I mean, that may be partly true in terms of how we use the curves, but ultimately, people die or they don't die. Money comes in or it doesn't come in.

Jay: Well, yeah, except you've only seen a very small segment of the survival distribution. This is the answer to one of the other questions, which I think we can address when we sit down together, and it's especially addressable if we collectively can pool our data. If we collectively can pool our data, a lot of these issues that we're debating here will completely disappear, completely.

So, by the way, did you have any questions for him (Alan)?

Adam: Well, I mean, I think you already just chimed in enough, too. I think, at the end of the day, all, look, as an investor, all I can look at is what half my portfolio do compared to what I thought it was gonna do, right?

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And if I take, maybe it's a language issue, but if I take the LEs as given, and I take the curves as given, and I'll take your point that maybe I'm using them wrong, but if people died the way you're suggesting they do and have based on your data, we should have some people in this room jumping up and down and telling me how wonderfully excessive their performance has been compared to what they see from the other LE providers.

Jay: Well, you do realize that over 95% of all the maturations that have occurred in our entire database occurred earlier than our point estimate.

Alan: It has no meaning.

It has no meaning.

Jay: Thank you for saying that. I hope you realize the importance of that.

It means that what we should be looking at is the target. The target is not how long or short you are relative to someone else. We actually don't care.

Alan: That's the problem, and I apologize, Jay. I don't mean to be short. But when you say you don't care, you're saying that the fabric of our industry isn't important, and that's not acceptable.

I'll finish, and then you can tear me apart. But when you say it's not your issue how the investors do, you don't have a place in the industry. And I'll go back to the 200 deaths that you observed on the population that you underwrote for us.

And I'll ask you, rather than tell you what we think, did you happen to calculate how many deaths you thought you should have had?

Jay: So, I'll say this a third time. You are only seeing the far-left side of the survival distribution.

Alan: But you said 200 deaths. You had a number. It was your number.

It wasn't my number. Although it agrees with my number. So, if you can calculate the deaths, you should have been able to calculate how many deaths you expected.

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Jay:	Calculating the number of deaths is heavily influenced by survival distribution. You can only see.
Alan:	I don't know what it means.
Jay:	That's why we need to sit down and really discuss exactly how this information could and should be used. You have to realize, you can't compare us to another company that may have data that has been evaluated for 10, 15, 20 years. On our side, the only thing you are seeing is the left side of the survival distribution.

You have to realize. |
| **Alan:** | Again, I think that's nonsense. We have, in terms of data, because we're a data-driven company, too. we're not academics and we're not scientists, but we are data-driven.

We have over 100,000 discrete lives that have been underwritten over 25 years. We own the AVS database and we have all the lives that have been underwritten for us, both secondary, primarily secondary, but also tertiary. And we have many of the lives that, like you said, have been underwritten more than once because we service them, we update, and so on.

We have a good idea of what mortality should be. And more importantly, we have a good idea of what mortality looked like. It doesn't look like anything remotely related to what you're doing.

And the fact that you, for some reason, can't say you can calculate the expected deaths when you can say, well, you had 200 deaths, and can't say, and we expected 200 deaths, or we expected 230 and we're a little low, or we believe 330, is, to me, undermining, and it's why we published what we did. It's because... |
| **Jay:** | But you published what you did without even consulting us.

You never even came to us and said, Jay… |
| **Alan:** | And it's a very valid point, and I apologize for that, and I apologize to you, and I'll tell you why I did it. Okay?

Most of the people in the audience know, years ago, like 21, 22 years ago, we sued two medical underwriters. And in each case, I went to the underwriters in advance. In one case, I flew up to, I flew out to the Midwest in the middle of winter. |

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Adam: Alan, Let me just interrupt. Okay, I have a question for you. The question goes like this.

Aren't Coventry's press releases concerning Lapetus just a continuation of a pattern of Coventry going after life expectancy providers? They give LEs that means Coventry doesn't like. I'm asking that because Jay feels I'm not asking enough questions.

And your answer is a yes.

Alan: I don't know what the definition of a pattern in this context is, but insofar as we don't know, we did do the two lawsuits 22 years ago.

And we met in each case in advance with no satisfaction. And frankly, I wouldn't have had any. In the day I spoke to you before we released it (the press release), it was clear I wouldn't have any satisfaction in going through it with you.

I don't have any now. (laughter) So I made the judgment, I'm not gonna get satisfaction. Let's go ahead.

My bad for not giving you a heads-up, but it is what it is. In terms of a pattern, I will go after as long as I have involvement in this industry. I will, and I don't like the phrase go after, but since he used it.

If I believe that something, and we're talking about life expectancies, is, and I'll say this overused term, that I think life expectancies that are so far out of the norm, that are so wrong, that are so short, that they represent an existential threat to the industry, you bet your ass I'll go after them. Because we need a balance between investors and consumers. If we get out of whack, materially out of whack, this industry will not survive.

And my focus, since we started this, I believe the value proposition of the consumer and the investor is extraordinary. And anything that threatens that, and I can't sugarcoat it, I think your life expectancies threaten that. And I'll take it on.

Jay: So actually, I think this is an important observation. And I think it would be useful for the industry if we could actually resolve this. And we proposed for a while to work with you and as best as possible, and in the end, I think the one most important thing that you and I have in common, which we've talked about before, is that we think that this industry is incredible.

And it should be a whole lot larger than it is now. So, the question is, how can we use this discussion, this debate, to enhance the industry, to increase the number of people that come into it? Because we all

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know that this is an incredibly valuable resource.

An incredibly valuable resource. We would not be in this industry if we didn't buy into the entire logic and line of reasoning of the industry. We are experts in survival analysis.

This is what we've been doing for decades prior to the existence of this industry. We want you to use us as scientists. I've got a team of PhD research scientists.

We've got dozens of doctors with expertise in estimating survival at the individual level. How can we find a way, collectively, to work together so that we can grow this industry far beyond where it is today? In the end, I think that's the value of this particular discussion that we're having.

And I think that's what we agree on the most. Wouldn't you suggest that?

Adam: I think that's an interesting observation and point that can make sense. I think there's definitely some language difference in terms of what we think you're saying in your reports and how we use them. We're out of time, but I was told we can get extra time. So I would really like to actually open it up if there's some questions in the audience.

If not, I've got 25 more.

Bryan: Adam, we can go for about 15 minutes or more.

Adam: Okay. I can't see who has questions.

Bryan: Someone over here.

Vince Granieri: I'm Vince Granieri of Predictive Resources. There's so much to discuss here that I'm going to avoid discussion of.

But I think the important point, as an actuary, when I see this chart come up, after the discussion we've had about general population and insured populations, and hear that there's no difference as proven by this actuarial study, you don't need to look any further than the bottom where it says there's no difference, assuming you've normalized for socioeconomic equivalency, which is exactly what Alan was trying to say.

You have to normalize for socioeconomic equivalency, and since our population is different than the general population with that regard,

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then this study can't be applied directly. And I'll save questions and other comments.

Jay: Except to say that we've already normalized for socioeconomic equivalency in the work that we do.

So that's exactly what we've been doing. Remember I said earlier, you can actually mimic precisely a mortality distribution instead of death rates for an insured population by using a general population and a subgroup within that. Remember, a mortality distribution for a population is a composite.

It's a composite of people that are gonna die early, people that are gonna die early, people that are gonna live long. It's just a simple composite. All we've done is identify the subgroup that's likely to live longer.

But the distribution of death looks virtually identical, slightly shifted.

Vince: No, but you use that as the basis for your legitimacy of the general population, and you say, okay, I've adjusted for that. Well, that's good, we can talk about those methods.

But don't say that the actuaries have agreed with you that there's no difference, because they've done the adjustment as well. And once they've done the adjustment, then there's no difference.

And it really is, the general population has great use for us, but because everybody's going there, and you've proven. Everybody eventually gets to population mortality. The question for life settlements is how do they get there?

Where they start, and how it erodes into general population mortality.

Jay: But you and I both know that the 1.0, the frame of reference, is not an insured population. In the medical literature, and that's what we use. Remember, we do medical reviews.

When you do medical reviews, the frame of reference has to match.

Vince: Absolutely. But let me say this. You presumed you understand how IULEs and how 21st and the others do LEs.

Yes, you have. You said all the other guys do it this way. We use life settlement data to develop R-hazard ratios as well.

So don't say that you know how I do things, and here's where I'm

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wrong, or how everyone else is wrong, because I am taking it personally.

Unknown: Sorry about that.

Vince: Okay, but because I do the same thing, right? You can't discount anyone else's methodology that you don't fully understand, nor am I going to do that to you, because I don't understand everything in your methodology.

It just isn't fair.

Alan: Let me quote a well-noted, well-respected academic scientist.

Jay: Yeah.

Alan: "Based on an insured population with an average age 77, most of whom are seeking to sell insurance policies with face amounts of a million dollars or higher, the risk of deaths for this select, wealthier segment of the population are considerably lower than that observed at the national level." You (Jay) said that. We all agree that's true.

Many of us, certainly I, I'll speak for me, believe that's why, because I still don't get it. Double counting. Believe that's why you've got to use an insured.

It doesn't have to be VBT, and if it's VBT, it's got to be adjusted in any event. But it should be an insured population or an annuity population, but not a general population. Let me just say one really important thing.

You've made a point, and I think you provide a valuable service, although I confess I don't think we've availed it. I haven't seen the results of it. We have availed ourselves of it, but I think it's a really telling number, and I'd ask you to really think about this, and maybe we can have a follow-up conversation.

We looked at our data, the 4,000, and I did this personally, and then I had people validate it. Of the people you thought were healthy, or better than healthy. Approximately 300, where the other underwriters thought the same thing, that they were healthy or better than healthy, preferred, whatever you call it.

There was a 48-month difference, where all underwriters in this subgroup thought the insured was a healthy or better than healthy individual, and when we paired your healthy people with the healthy

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people of the other underwriters, they were 48 months longer. That has nothing to do with their medical conditions. That has entirely to do, in my uninformed way, I'm not an academic, it seems to me that has entirely to do with the base table you're using, because you're saying, and the other underwriters are saying these are healthy people, and so your starting point, your baseline, is 48 months shorter.

Jay: So you do know, of course, that we did ask you for the data that you used. We did ask you for the methods.

Alan: We couldn't give you, we told you the methods, and we had it reviewed by a professor, but we couldn't give you the data of other underwriters.

Jay: You had replicated by someone else. You didn't have it validated by someone else.

Alan: Look, do you believe it's wrong?

Jay: Yes.

Alan: Do you believe it's materially wrong?

Jay: Yes. I can actually explain why.

Alan: Last question.

Do you know how many deaths of, where you said we had 200, do you know how many you expected?

Jay: You're asking the wrong question.

Alan: Can you calculate it?

Jay: We could.

Alan: You have on your website that you have a 96.3% actual to expected, and your actual to expected is done by an actuary who does nothing in the life settlement business.

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Jay:	Really, seriously, would you guys like to sit down and work together to do the calculations?
Alan:	If you're willing to make some changes, I would embrace it.
Jay:	Are you willing to make changes?
Alan:	You know what's happened for 25 years. I can't change them. They're dead already!
Jay:	All right, I think we're going in circles, because we are not actually technically really crossing swords for a variety of reasons. It would actually make sense if we sat down and discussed data and methods.

And actually, I would love it if some of our other colleagues that are also generating LEs would all come together collectively and have a discussion about how we can improve the industry. I mean, would my colleagues from the other LE companies be willing to sit down and have a summit? |
| **Unknown:** | Only if it's televised. |
| **Bryan:** | Gents, I know that there are a number of other folks that are in the queue to ask questions. Jay, I think it is a great suggestion. I'm happy to continue that conversation, but just in the interest of time, John has a question here. |
| **John McFarland:** | So, without pandering, I think you're both right, that, Jay, we have a responsibility in our marketplace to back into the cost of insurance rates applied by those, applicable by the survival, mortality coverage by the carriers themselves. So, a different distribution, right, doesn't work in us solving the net present values, which is what we use the LEs for, right? So, you're proposing probably a really smart, intelligent way to come up with the life expectancy, but with a distribution that carriers are not using for the economic constructs of the policies.

And that is the fundamental disconnect. |
| **Bryan:** | Any other questions from the audience? Well, we have five minutes. |
| **Adam:** | I still have more than (unclear) |

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Bryan: Yeah, absolutely, go ahead.

Adam: So, one question that did come up was this idea that is Coventry's
press release really predicated on really the competitive issues of the
attack on Abacus, some relationships there. So, I'm curious about that.

Alan: You're asking Jay?

Adam: No, no, I was asking you.

Alan: I don't think it's appropriate for at a LISA event for me to comment on
Abacus or any other particular competitor.

I will say the following, though, without commenting on Abacus.
We've looked at our portfolio and evaluated those policies where we
have Lapetus life expectancies, and our valuation. And I'll throw out
numbers that are representative of what we've discovered.

If we had, using Lapetus, a fair market value of a pool of policies that
we calculated at a hundred, that the fair market value was $100
million. And using a discount rate of, let's say, 20 or 21%, we had a
fair market value.

Adam: Is that what you were gonna sell it to me at? (Laughter)

Alan: That's between you and Reid and Josh, okay?

Adam: I'll keep that in my pocket.

Alan: I said on policies we own, not policies you own.

Adam: Policies you own, you're gonna sell to me.

Alan: Again, using Lapetus at a discount rate of 21%.

If instead of using Lapetus at 21% where I have $100 million fair
market value, I used the two shortest that we're aware of because we
get submitted the next two shortest life expectancies.

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But I didn't use a discount rate of 21%, because 21%, we all know. And laugh at it. Not realistic.

I used a 12% discount rate. Now you think if I'm using a 12% discount rate, the value would go up.

But in fact, the value goes down—and we've done a lot of analysis on this—to about 62 million. 100 goes down, drops about 38% or to say it in reverse, using Lapetus, instead of the next shortest life expectancy is the average. At 12%, we get an increased fair market value of over 60% more.

Adam: Well, I think all you're really saying is you can't make up for the difference that you would with a discount rate, or at least not use it.

Alan: Well, I'm saying something I think is more important than that. That fair market value is grossly overstated, even if you use the 21%.

And that's, by my rough calculations, and knowledge of the market, I believe that, I'll say it this way.

I watched a TV show the other night. It was a detective show. A woman came into this private detective and said, I wanna hire you. And he said, for what? She said, I want you to solve my murder.

I've been murdered, I want you to figure out who did it. And he said, I don't understand. She said, I was given a long-acting poison, and I'm dead.

It's just gonna take another several days. And I want you to figure out who did this to me.

I believe $250 million, million dollars out there that investors have put up is debt.

And I worry that it's gonna be 300, 400, and 600, and a billion dollars. With Mutual Benefits, it was 800 million. And the long… it's gonna be awful for us, all of us. The longer it takes, and the bigger it gets, the worse it'll be.

Jay: This might actually be the first time that I could remember that I'm considered the optimist. If you've read any of my papers, any of my research, it's like, oh, Jay's the pessimist, there's a limit to how long we can live.

I'm the optimist. I actually think your company might be worth four billion instead of two billion.

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Alan: From your lips to God's ears. (laughter)

Adam: We're out of time, but I really hope you're right. That'd be great.

Alan: We're all rooting for you.

Adam: All right, thank you very much. Alan, thank you very much.