1. *Personal Information* – Completed by Insured:

First Insured's Name _____
First Middle Last

Address _____
Street Apt#

_____
City State Zip Code

Date of Birth _____/_____/_____ **Social Security #** _____-_____-_____

Home Phone (____) ____-_____ **Business Phone** (____) ____-_____

Email _____ **Mobile Phone** (____) ____-_____

Second Insured's Name _____
First Middle Last

Address _____
Street Apt#

_____
City State Zip Code

Date of Birth _____/_____/_____ **Social Security #** _____-_____-_____

Home Phone (____) ____-_____ **Business Phone** (____) ____-_____

Email _____ **Mobile Phone** (____) ____-_____

Marital Status: Married__Divorced__Widowed__ Dependent Children Yes__ No__

Are there any liens against your assets? Yes ____ No ____

Have you ever declared bankruptcy? Yes ____ No ____ Year _____

Have you ever been divorced? Yes ____ No ____ Year _____

How did you hear about us? _____

Referred by _____ **(IE doctor, brochure, or hospital)**

2. Policy Owner Information – Completed by Insured or Policy Owner

Full name of the Policy Owner:

_____
Full Legal Name Relationship to Insured

Name of Trustee(s) if trust owned:

_____
Full Legal Name Relationship to Insured

Address _____
Street Apt#

_____
City State Zip Code

Social Security # _____-_____-_____ Tax ID# _____-_____

Home Phone (____) ____-_____ Business Phone (____) ____-_____

Email _____ Mobile Phone (____) ____-_____

3. Insurance Policy Information – Completed by Policy Owner

Name of
Life Insurance Company _____

Type of Policy: Term ____ Whole Life _____ Universal Life_____
Group____ Converted Group_____ (Conversion Date) _____/_____/____

Policy Number _____ Face Amount of Policy $_____
Date of Issue _____/_____/_____

Premium Amount $_____ Monthly___Quarterly___Semi-Annual___Annual___

Date Last Premium was paid: _____ Date Next Premium is due:
_____

Has this policy ever lapsed? Yes_____ No_____

Who is the beneficiary of the policy? _____
Name Relationship

Is there a disability waiver of premium on your policy? Yes___ No___

If Yes, are the premiums being paid by this waiver? Yes___ No___

4. Medical Condition – Completed by Insured

What is your current medical condition? _____

Date of most recent visit to doctor _____/_____/____ To Hospital_____/_____/_____

When were you first diagnosed? _____/_____/_____

Who are your attending physicians?

_____ (____)_____-_____
Physician's Name Phone Number

_____ (____)_____-_____
Physician's Name Phone Number

_____ (____)_____-_____
Physician's Name Phone Number

5. Employment Information – Completed by Insured

Employer _____ Phone (____) _____-_____

Address _____
Street Apt#

_____
City State Zip Code

Are you currently working? Yes_____ No _____ Date of Hire _____/_____/_____

If not when was the last day you worked? _____/_____/_____

Are you receiving disability income? Yes_____ No_____

If yes, date of eligibility _____/_____/_____

Fraud Notice

Any person who knowingly and with intent to defraud any insurance company or other person files and application or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

6. Policy Information Release Form

To be completed by the Policy Owner or Trustee

I hereby authorize _____
(Full Name of Insurance Company)

Policy Number _____

Owned By _____

Insuring the life of _____

To release to R.C.T. Policies, FLP, its authorized employees, agents, representatives, successors, assigns or affiliates, any of the following information if requested by them.

- **A fully completed Verification of Coverage Form (VOC)**
- **A complete copy of the life insurance policy, including a copy of the application (employees certificate for group policies)**
- **Policy Illustrations**
- **Premium and Annual Statement Information**

I agree that this authorization is valid for twelve months from the date hereof, that a photocopy facsimile is as valid as the original, and that I may request a copy of this authorization.

_____ _____
Signature of Policy Owner Date

_____ _____
Typed or Printed Name of Policy Owner Date

_____ _____
Signature of Witness Date

7. Protected Medical Information Release **- To Be Completed By Insured**

Authorization For Disclosure of Protected Health Information

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

1. ***Classes of Persons Authorized to Disclose My Protected Health Information:*** I hereby authorize each physician, medical practitioner, hospital, hospice, clinic, health care provider, nurse, pharmacy, physician practice group, other medical or medically related facility, government agency, insurance company group, employer, benefit plan administrator, group policyholder and any other type of health care provider, person or institution (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photo static or facsimile copy or other reproduction of this authorization.

2. ***Classes of persons Authorized to Receive My Protected Health Information:*** I authorize each Authorized HCP to disclose my PHI under this authorization to R.C.T. Policies, FLP, its affiliates and any of its directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities or their representatives, brokers or agents, stop-loss re-insurers, potential purchasers or their representatives, brokers or agents, service providers or other representatives, brokers or agent which may have an interest in the purchase, sale or financing of the life insurance policy which is the subject of this transaction, prospective policy purchasers and its successors and/or assigns. (Each an "Authorized Recipient".) I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (each an "Authorized Recipient") will use the information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy(ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this Authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure website. I agree that a photocopy or a facsimile of this authorization shall be valid as the original.

3. ***Protected Health Information Authorized for Disclosure and Purpose of Disclosure:*** This authorization shall apply to the disclosure, inspection and copying of any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificated of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions there of replacements therefore, that R.C.T. Policies, FLP brokers.

4. ***Expiration:*** This authorization shall remain valid until, and shall expire, one year after the date of my passing.

5. ***Right to Revoke Authorization:*** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorization HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation .

6. ***Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization:*** I understand that this authorization is voluntary and I am not required to sign. No Authorized HCP of other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearing house or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the HIPPA Privacy Regulations). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may be protected by the HIPPAA regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and 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.

_____		_____
Signature of Insured	Date	Printed Name of Insured
_____		_____
Signature of Witness	Date	Printed Name of Witness

8. Terms and Disclosure

Receipt of payment pursuant to a viatical settlement may affect eligibility for public assistance programs such as medical assistance (Medicaid), family assistance, supplementary social security income and AIDS drug assistance programs and may be taxable. Prior to applying for a viatical settlement, policyowners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and the recipient's spouse or dependents, and with a qualified tax advisor.

There may be possible alternatives to selling your life insurance policy, including to option of obtaining accelerated benefits offered by the issuer of the policy, loans offered by the issuer of the policy and secured by the policy and surrender of the policy for a cash value. You are advised to consult your financial advisor, certified public accountant or attorney regarding these potential alternatives.

Some or all of the proceeds of your life settlement may be taxable under federal income tax and/or state franchise and income tax laws. You should consult a professional tax advisor.

The proceeds of a life settlement may not be exempt from the applicant's creditors, personal representatives, and trustees in bankruptcy and receivers in state or federal court. You are advised to consult your financial advisor, certified public accountant or attorney regarding these potential consequences.

You are not required to pay R.C.T. Policies, FLP any fees for this service. R.C.T. Policies, FLP will be compensated by either the end purchaser of the policy or by a viatical or life settlement provider company.

The applicant acknowledges receipt of consents to be examined by R.C.T. Policies, FLP or its agents and to the re-disclosure of any existing medical records by R.C.T. Policies, FLP for the uses and purposes as stated in the Authorization For Disclosure of Protected Health Information. The applicant consents to this settlement and represents that he or she has a full and complete understanding of the settlement, that he or she has a full and complete understanding of the benefits of the life insurance policy, releases his or her medical records, and acknowledges that he or she has entered into this settlement freely and voluntarily. The applicant agrees to provide R.C.T. Policies, FLP, its employees and agents, any and all information that R.C.T. Policies, FLP may request from the applicant or any third parties from time to time.

The applicant warrants and represents that all information contained in this application is true and correct to the best of his/her/their knowledge. The applicant herein includes a photocopy of a driver's license or picture identification and swears and warrants that he/she is the person identified thereby.

By my/our signatures hereinafter affixed, I/we confirm, acknowledge and agree that I/we have read this entire application and understand the terms and contents thereof: Yes_____ No_____

I state that all information provided in this application is true and accurate to the best of my knowledge and belief: Yes_____ No_____

_____ _____

Signature of Policy Owner Date

_____

Printed Name of Policy Owner

9. Agent of Record for Life Settlements

I, _____, owner of policy number _____
(Policy Owner) (Policy Number)

with _____ insurance company, have agreed to the
(Name of Insurance Company)

sale of this policy as a life settlement.

I hereby appoint R.C.T. Policies, FLP as my agent of record for the above mentioned policy and hereby grant R.C.T. Policies, FLP the exclusive right to broker this policy.

_____ _____
Signature of Policy Owner Date

_____
Address State Zip Code

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

HIPAA PRIVACY NOTICE

This notice describes how personal health information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Protected Health Information.

Who/What is Covered by this Notice?

This Notice of Privacy Practices covers all facilities, programs, employees, and all other support staff of R.C.T. Policies, FLP ("Ideal"). This Notice applies to all Protected Health Information maintained by Ideal. This includes records of your care maintained by Ideal, whether created by your physician, consulting physicians any other health care providers. The records of your medical care maintained by Ideal are referred to as Protected Health Information.

How We May Use or Disclose Your Protected Health Information

Federal and State Law Implications

HIPAA is a federal law, which places limitations on the types of uses and disclosures health care providers and others may make of Protected Health Information. At times, State or other regulations may be more stringent than HIPAA. Ideal will abide by the regulations as they pertain to Protected Health Information.

Uses and Disclosures under HIPAA

1. **We May Use or Disclose Your Protected Health Information without Obtaining Your Prior Authorization and Here are examples of situations where this may occur:**

   Internal Assessments - Your Protected Health Information may be provided to our physicians or other support medical support staff to analyze, assess, and evaluate your health or medical condition or life expectancy.

   Internal Functions - We may access or send your information to our attorneys, accountants, or other personnel in the event we need the information in order to address one of our own business functions.

2. **Protected Health Information Will Also Be Used Without Prior Authorization Under the Following Circumstances:**

   As Required by Law — Protected Health Information will be used and disclosed, to the extent that law requires such use or disclosure.

   In Response to Subpoenas or for Judicial and Administrative Proceedings — In general, Protected Health Information will be used and disclosed in the course of an administrative or judicial proceeding. However, we will attempt to ensure that you have been made aware of the use or disclosure of your protect health information prior to its release.

   To Law Enforcement Personnel — Protected Health Information will be used and disclosed to law enforcement officials to identify or locate a suspect, fugitive, material witness or

missing person, or, in some cases, to comply with a court order or subpoena and for other law enforcement purposes.

3. Required Uses and Disclosures:

Under the law, disclosures must be made to you, upon your request and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance with HIPAA regulations.

4. **For All Other Circumstances, We May Only Use or Disclose Your Protected Health Information After You Have Signed an Authorization.**

If you authorize us to use or disclose your Protected Health Information for another purpose, you may revoke your authorization in writing at any time. However, the revocation will not be effective to the extent that Ideal has taken action in reliance on the use or disclosure allowed by the Authorization.

5. We May Also Use or Disclose Your Protected Health Information for the Following Purposes:

Monitoring or Tracking Purposes - To monitor, track or verify your health or medical status and condition as necessary

Change of Ownership - In the event that one or more of your life insurance policies are sold or transferred to a new owner so that the policy becomes the property of the new owner.

Your Rights with Respect to Your Protected Health Information

1. You have the right to request restrictions on the uses and disclosures of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must be in writing, be addressed to the Privacy Officer and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request.
2. You have the right to request your Protected Health Information through confidential means. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer and state the specific alternate means or location.
3. You have the right to inspect your Protected Health Information. You may also obtain a copy of your Protected Health Information. Ideal will charge a reasonable fee for the copying of records. This means you may inspect and obtain a copy of your Protected Health Information that is contained in Ideal's designated record set for you. A "designated record set" is the HIPAA term for medical records and any other records that Ideal uses for its operations.
4. You have a right to receive an accounting of disclosures of your Protected Health Information made by us, except that we do not have to account for disclosures: made

prior to April 14, 2003; authorized by you; provided in response to an Authorization; made in order to notify and communicate with family; for certain government functions, and/or disclosures provided to you, to name a few. The right to receive an accounting is subject to exceptions, restrictions and limitations.

5. You have a right to a paper copy of this Notice of Privacy Practices upon request, even if you have agreed to accept the Notice electronically.
6. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Patient Representative or the Privacy Officer.

Our Duties to You

We are required by law to maintain the privacy of your Protected Health Information and to provide you with a copy of this Notice. We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Protected Health Information - even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office, and on our Web Site at www.Idealsettlements.com. We will also provide you with a copy, at any time, upon request.

How You May Contact us about our Privacy Practices

You may contact us about our privacy practices by e-mailing amatolaw@gmail.com. *E-mails received Monday through Friday during business hours should receive a response within 24 hours. E-mails received Saturday and Sunday should receive a response on Monday.*

Last revision 01/01/2013