



# IMS ASSOCIATES

A LIFE SETTLEMENT BROKERAGE

## SMALL LIFE SETTLEMENT INFORMAL APPLICATION

This checklist was designed to help you ascertain if you have completed all pertinent items in order to expedite processing of the life settlement.

### The following items must be received by IMS in order for the policy to be processed:

- Application must be filled out completely, signed and witnessed. Anything that is not applicable, mark "N/A".
- Insured's photo ID** - Accepted forms of identification are photocopies of a driver's license or passport. Identification must be current not expired.
- Complete copy of the insurance policy.** If this is not available immediately, please make a note for us on the application and forward as soon as possible.
- Current in-force illustration** from the insurance company with application showing the following:
  - Universal Life – minimum premium payment to age 100.
  - Term – proposed conversion illustration to Universal showing a minimum payment to age 100.
  - Whole Life – run a natural vanish premium illustration to age 100.
- Owner and Beneficiary (ies) of the policy.
  - If owner/beneficiary is a trust, we need:
    - Copy of trust and Tax ID#**
    - Trustee (s) must sign the policy information release form
  - If owner/beneficiary is a corporation, we need:
    - Complete name and address of corporation.
    - Corporate resolution showing current authorized officers.
    - Two officers must sign the policy information release form.

### AGENTS MUST COMPLETE:

Representing Agent \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Is the representing agent the writing agent on the policy? \_\_\_\_\_  
Has this policy been or will this policy be submitted to another life settlement company? \_\_\_\_\_  
Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

### IMS CONTACT INFO:

2741 Walnut Ave, Suite 100  
Tustin, CA 92780

Phone: 800-914-9483  
Fax: 714-634-3972

[www.IMSSettlements.com](http://www.IMSSettlements.com)

# Life Settlement Application

## INSURED'S INFORMATION 1

Insured's Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street Address (No PO Box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Fax # \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex  Female  Male  
Is there a Power of Attorney \_\_\_\_\_ If Yes, list who and provide copy \_\_\_\_\_  
Spouse's Full Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

## INSURED'S INFORMATION 2

Insured's Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street Address (No PO Box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Fax # \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex  Female  Male  
Is there a Power of Attorney \_\_\_\_\_ If Yes, list who and provide copy \_\_\_\_\_  
Spouse's Full Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

## EMPLOYMENT STATUS

Are you currently retired?  Yes  No Do you work?  Yes  No  
Current employer and occupation \_\_\_\_\_

## LIFE INSURANCE POLICY INFORMATION

(please provide for each policy being offered for sale)

Name of Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_ Face Value \$ \_\_\_\_\_  
Cash Value \_\_\_\_\_ Cash Surrender Value \_\_\_\_\_  
Loan Amount \_\_\_\_\_ Face Value Net of Loan \_\_\_\_\_  
Policy Issue Date \_\_\_\_\_ Insuring  Individual  Survivorship  
Policy Type -  Universal  VUL  Term  Whole Life  Group **Rate Class at Issue** \_\_\_\_\_  
If term policy, can it be converted until what date? \_\_\_\_\_  
Annual Premium \_\_\_\_\_ Paid  A  SA  Q  M  
Next premium due date \_\_\_\_\_  
Owner of Policy \_\_\_\_\_ Tax ID# \_\_\_\_\_  
Is there a Power of Attorney \_\_\_\_\_ If Yes, list who and provide copy \_\_\_\_\_  
Owner Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Complete Trust or Corporation name, and names of Trustee(s) or 2 officers  
\_\_\_\_\_  
\_\_\_\_\_

Beneficiary (ies) \_\_\_\_\_  
Primary Beneficiary Address \_\_\_\_\_

Reason for selling \_\_\_\_\_  
Has an application for insurance on insured's life/health ever been declined, rated or modified in any way  
(including this policy)?  Yes  No  
If yes, give company and reason \_\_\_\_\_

Does the insured have plans to purchase new life insurance? \_\_\_\_\_  
Total face value of life insurance NOT being offered for sale herewith \_\_\_\_\_

**MEDICAL INFORMATION**

Please list any specific health conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has insured smoked:  Cigarettes  Cigars  Cigarillos  Pipe in past 12 months?  No  
Does insured use or has ever used alcoholic beverages?  Yes  No If yes, answer the following:

- (A) Frequency of use  Daily  Weekly  Monthly  Occasionally
- (B) Amount consumed on each occasion \_\_\_\_\_
- (C) Any treatment for alcohol use (including AA treatment) \_\_\_\_\_

**FAMILY HISTORY** Current Age Deceased? If deceased, cause and age at time of death

- (A) Father \_\_\_\_\_  Yes  No \_\_\_\_\_
- (B) Mother \_\_\_\_\_  Yes  No \_\_\_\_\_
- (C) (Brother) (Sister) \_\_\_\_\_  Yes  No \_\_\_\_\_
- (D) (Brother) (Sister) \_\_\_\_\_  Yes  No \_\_\_\_\_

Please list insured's Primary Care Physician:

1) Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Date last seen: \_\_\_\_\_

2) Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Date last seen: \_\_\_\_\_

Please list Specialists that insured has seen:

1) Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Date last seen: \_\_\_\_\_

3) Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Date last seen: \_\_\_\_\_

*Attach additional pages if needed.*

**FINANCIAL**

Has insured applied for or received a pension or compensation because of illness or injury?  Yes  No  
If yes, give details of illness or injury: \_\_\_\_\_

Has owner been a party to a: (check all that apply)  Civil Suit  Bankruptcy  Judgments  Creditor Liens  Tax Liens  
*Explain any checked answers on a separate page and attach all discharge papers.*

Does insured have a living will?  Yes  No

**PERSONAL ACKNOWLEDGEMENT**

I represent and warrant that the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify Insurance Marketing Services, Inc. dba " IMS Associates Financial & Insurance Services" of any changes in the information. I further give my consent to IMS Associates Financial & Insurance Services and its agents to release this application and all information gathered while processing it as necessary for the sole purpose of soliciting the purchase of my life insurance policy. I acknowledge that I am submitting this application IMS Associates Financial & Insurance Services to evaluate the purchase of my life insurance policy and that IMS Associates Financial & Insurance Services is under no obligation to purchase my policy. I acknowledge I may be contacted IMS Associates Financial & Insurance Services regarding the information contained in this application. I understand that some or all of the proceeds from a life settlement may be taxable and that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that neither IMS Associates Financial & Insurance Services nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

Owner's signature \_\_\_\_\_  
Typed or printed name \_\_\_\_\_ Date \_\_\_\_\_  
Witness signature \_\_\_\_\_  
Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**NOTICE OF DISCLOSURE**

1. There may be alternatives to a life settlement contract including, but not limited to, accelerated benefits, loans secured by the policy, and surrender of the policy for cash value offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. We encourage you to contact the issuer of your policy to discuss these other benefits.
2. 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. Insurance Marketing Services, Inc. dba "IMS Associates Financial & Insurance Services" strongly urges you to consult your own attorney or tax advisor concerning this transaction. IMS Associates Financial & Insurance Services makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of any life settlement or viatical settlement transaction.
3. Some or all of your life settlement proceeds may adversely affect your eligibility for social security income, public assistance, public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Proceeds from a life settlement may not be exempt from claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents or others, there may be a loss of coverage. We urge you to contact the issuer of your life insurance policy for information on these provisions.
6. Entering into a life settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy to be forfeited by you.
7. All medical, financial or personal information solicited or obtained by IMS Associates Financial & Insurance Services about the insured & owner, including the insured's & owner's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the life settlement between you and IMS Associates Financial & Insurance Services. If the insured or owner is asked to provide this information, the insured & owner will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. The insured may be asked to renew his or her permission to share information every two years.
8. The insured may be contacted by IMS Associates Financial & Insurance Services or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months.
9. Funds will be sent to you within the stated time in the closing documents once all parties have received the insurer's or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.
10. You are encouraged to contact an attorney, accountant, financial planning advisor, insurer, tax advisor or social services agency regarding potential consequences resulting from entering into a life settlement.

I acknowledge that I have read and understand the contents of this disclosure.

Owner's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Typed or Printed Name \_\_\_\_\_

Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Typed or Printed Name \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

IMS Associates Financial & Insurance Services  
2741 Walnut Avenue, Suite 100 • Tustin, CA 92780



## **HIPAA Underwriting Authorization**

I hereby understand the necessity for personal medical information to be released to facilitate complete and thorough underwriting. Therefore, I authorize any health care provider, not limited to any one type or source, to release all personal medical records, including information related to the diagnosis or treatment of Human Immunodeficiency Virus, sexually transmitted diseases, suicidal or mental disorders, and all other information concerning my health to Insurance Marketing Services.

I authorize and instruct my insurance providers to release and disclose my entire medical record without delay or restriction.

This personal and protected health documentation is to be released and disclosed to Insurance Marketing Services, for the purpose of underwriting decision, to obtain insurance, and to authorize other legally permitted actions that relate to coverage for which I have applied with any of the insurance institutions named in this document

This document is valid for a period of no longer than 24 months following the date of my signature. If for any reason I wish to terminate this document I may do so in writing to:

**Insurance Marketing Services, Inc.**  
**dba**  
**"IMS Associates Financial & Insurance Services"**  
**2741 Walnut Avenue, Suite 100**  
**Tustin, CA 92780**

A revocation is not effective if any of my providers have relied on this information or to contest the policy itself. I also understand that information disclosed pursuant to this authorization may be disclosed and no longer covered by certain federal rules governing privacy.

The applicant agrees and understands that the applicant has filed an application with Insurance Market Services, Inc. for life insurance or to secure another financial product or service. During this application Insurance Marketing Services, Inc., has asked for underwriting information and medical necessities from the applicant. This information will be provided to and shared with potential underwriters, staff, and internal support for the sole purpose of underwriting. This information may be stored in an electronic database in which internal users may have access for review. This electronic storage of information allows underwriters and staff to review the stored information real-time for efficient decision making. Secure measures are always strictly enforced to protect unauthorized users from gaining access to this secure information. However, Insurance Marketing Services, its affiliate company, shareholder, staff, or any other associate member of Insurance Marketing Services Inc., is not liable or responsible if a security breach occurs due hackers or others who gain access.

The applicant will hold Insurance Marketing Services, Inc. harmless for any unauthorized access to or use of by any person or company any of the above information.

## **Privacy Policy - Due Diligence**

Insurance Marketing Services, Inc., may collect public, non-public, and private personal health and financial information about you from any, or all, of the following sources:

1. Information received from your personal application, medical records, additional forms and questionnaires.
2. Personal business transactions with the aforementioned institutions and product sponsors.
3. Third-party, non-affiliate companies, such as credit reporting agencies.
4. Affiliated and unaffiliated product sponsors in which we have a solicitation agreement with and whose products you may

## HIPAA Underwriting Authorization (Continued)

### Disclosure of Information

Insurance Marketing Services, Inc., does not share non-public or private information about our past, present, or future clients with any third party except where permitted by law. Insurance Marketing Services, Inc., will not share any of this information for marketing purposes except where permitted by law.

Examples of third parties that we would likely share information with include, but are not limited to:

1. Insurance institutions, financial institutions, insurance support companies, life expectancy consultants, and other entities which directly affect and influence purchases and sales of insurance and the maintenance of your personal insurance coverage of accounts.
2. Securities clearing agencies.
3. Third-party investment advisory forms where we maintain relationships for the management of customer accounts.
4. Regulatory or federal, state, or municipal authorities.
5. Record keeping companies.

### Protection of Information

Insurance Marketing Service, Inc., is determined to uphold and enforce the strictest security measures available today. It is our duty to update these systems periodically. Your information as mentioned above is only available to parties requiring access to process, underwrite, and service your account. These safeguards are constantly monitored to ensure protection within federal, state, and municipal regulations.

The insurance carriers and agencies represented below uphold the highest degree of security and confidentiality. The applicant has reviewed the companies listed below and understands that any or all of the institutions listed may be used to secure the best insurance or financial offer.

- |                      |                     |                       |
|----------------------|---------------------|-----------------------|
| • 21st Services      | • IMS Associates    | • Principal Financial |
| • American General   | • Hartford          | • Protective Life     |
| • Allianz            | • John Hancock      | • Prudential          |
| • American National  | • Lincoln Benefit   | • RBC/Liberty         |
| • AVIVA              | • Lincoln National  | • SBLI                |
| • AVS                | • LSW               | • Transamerica        |
| • AXA                | • Mass Mutual       | • Union Central       |
| • Banner             | • MetLife Investors | • United of Omaha     |
| • EMSI               | • Minnesota Life    | • West Coast Life     |
| • Fasano             | • Mutual of Omaha   | • Western Reserve     |
| • Fidelity Life      | • NACOLAH           |                       |
| • Genworth Financial | • Nationwide        |                       |
| • ING                | • New York Life     |                       |

### Signature Authorization

I have read and completely understand this document. I have the right to rescind my authorization as described above. I have received a copy of this document. I agree this document shall be valid for a period of twenty-four (24) months from the date below.

\_\_\_\_\_  
Signature of Proposed Insured/Parent or Guardian

\_\_\_\_\_  
Printed Name of Proposed Insured/Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Signature of Witness



## SIMPLIFIED SETTLEMENT QUESTIONNAIRE

(Please print clearly)

### Insured Medical Information

1. Name of insured \_\_\_\_\_ date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Height \_\_\_\_\_ weight \_\_\_\_\_ sex  male  female social security number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Insured's Lifestyle and Habits

3.  Yes  No Has your weight changed in the last year?  
If yes, provide details: \_\_\_\_\_
4.  Yes  No Do you currently, or have you ever smoked cigarettes?  
If yes, for how many years? \_\_\_\_\_ If yes, how many daily? \_\_\_\_\_  
Date of last use (if currently smoking, write "current"): \_\_\_\_\_
5.  Yes  No Do you use any other form of tobacco?  
If yes, indicate type and frequency: \_\_\_\_\_
6.  Yes  No Do you drink beer, wine or spirits?  
If yes, indicate type and amount of drinks consumed per day: \_\_\_\_\_
7.  Yes  No Are you currently employed?  
If yes, indicate occupation: \_\_\_\_\_
8.  Yes  No Are you involved in hobbies, clubs, organizations or volunteer work?  
If yes, provide details of type and frequency: \_\_\_\_\_  
\_\_\_\_\_
9.  Yes  No Do you have a valid driver's license?
10.  Yes  No Do you currently engage in sports or regular exercise?  
If yes, provide details of type and frequency: \_\_\_\_\_
11.  Yes  No Do you live alone?  
If no, do you live with a spouse or significant other: \_\_\_\_\_
12.  Yes  No Do you live in an assisted living facility or nursing home?
13.  Yes  No Are you the primary caregiver for a dependent family member?  
If yes, provide details: \_\_\_\_\_
14.  Yes  No Do you require assistance to perform any of the following activities? (Circle all that apply)  
meal planning      taking medication      driving      shopping      walking      bathing      dressing  
If yes, provide details: \_\_\_\_\_
15.  Yes  No Do you use any non-prescription alternative treatments such as herbal remedies?  
If yes, provide details of type and frequency: \_\_\_\_\_  
\_\_\_\_\_

**Medical History, Conditions and Treatments** *(Circle all conditions that apply and provide details in the section below)*

In the past five years, have you been diagnosed with or treated for any of the following conditions?

16.  Yes  No Disease or disorder of the heart including high blood pressure, atrial fibrillation, irregular pulse or other cardiac arrhythmia, heart attack, coronary artery disease, chest pain, angina, valve disease or other heart disorder?
17.  Yes  No Circulatory or blood vessel disorder including stroke, TIA (mini-stroke), aneurysm, arterial blockage in the neck, abdomen or legs, venous disease such as blood clots, thrombosis, embolism or any other?
18.  Yes  No Cancer, tumor or malignancy? *(Please provide details regarding exact type, stage, metastasis, treatment or surgery, results and any ongoing therapy)*  
 \_\_\_\_\_  
 \_\_\_\_\_
19.  Yes  No Any immune system disorder?
20.  Yes  No Disease or disorder of the digestive system including diabetes, liver disease, colon, intestinal, stomach disorder or any other?
21.  Yes  No Infectious disease (other than common colds and flu) including hepatitis, pneumonia, sexually transmitted disease, shingles or any other?
22.  Yes  No Disease or disorder of the lungs or respiratory system including asthma, emphysema, COPD, chronic bronchitis, shortness of breath or any other?
23.  Yes  No Genitourinary problems including disease or disorder of the genitalia, breasts, prostate, bladder, kidney or any other?
24.  Yes  No Abnormality of the blood and platelets including anemia, high cholesterol or any other?
25.  Yes  No Bone or joint abnormality, paralysis, trauma, injury or physical impairment, including problems with balance or walking?
26.  Yes  No Neurological disorders including Parkinson's disease, multiple sclerosis, loss of consciousness, convulsions or epilepsy, loss of vision, loss of hearing, neuropathy, chronic pain or any other?
27.  Yes  No Mental or nervous disorder including memory or cognitive impairment, dementia, psychiatric disorder or any other?
28.  Yes  No Have you ever been treated for alcohol or drug abuse, or told by a physician or practitioner to reduce or eliminate alcohol or drug use?
29.  Yes  No Have you been diagnosed with, been treated for, had surgery or are currently being treated for any other disease or disorder not previously given?

**Further Medical History Details** *(Use the back page and attach additional pages as necessary)*

If you answered "yes" to any of questions 16 - 29, please provide details below for each condition circled.

Question number \_\_\_\_\_ diagnosis \_\_\_\_\_ date of diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 date last treated \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ type of treatment(s) received \_\_\_\_\_  
 results \_\_\_\_\_

Question number \_\_\_\_\_ diagnosis \_\_\_\_\_ date of diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 date last treated \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ type of treatment(s) received \_\_\_\_\_  
 results \_\_\_\_\_

Question number \_\_\_\_\_ diagnosis \_\_\_\_\_ date of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
date last treated \_\_\_\_/\_\_\_\_/\_\_\_\_ type of treatment(s) received \_\_\_\_\_  
results \_\_\_\_\_

Question number \_\_\_\_\_ diagnosis \_\_\_\_\_ date of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
date last treated \_\_\_\_/\_\_\_\_/\_\_\_\_ type of treatment(s) received \_\_\_\_\_  
results \_\_\_\_\_

Question number \_\_\_\_\_ diagnosis \_\_\_\_\_ date of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_  
date last treated \_\_\_\_/\_\_\_\_/\_\_\_\_ type of treatment(s) received \_\_\_\_\_  
results \_\_\_\_\_

Family History, Prescription Medications and Physician Information (Use the back page and attach additional pages as necessary)

30. Mother's age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

31. Father's age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

32. Sibling age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

Sibling age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

Sibling age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

Sibling age, if living \_\_\_\_\_ if deceased, age at death \_\_\_\_\_ cause of death \_\_\_\_\_

33. Please list all prescription medications currently being used:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

34. Please provide the name and address of your primary care physician, noting date and reason for last visit:

Name \_\_\_\_\_ address \_\_\_\_\_

date last seen \_\_\_\_/\_\_\_\_/\_\_\_\_ reason for visit \_\_\_\_\_

The undersigned insured and agent hereby represent and warrant that any and all information provided in this questionnaire is true and correct as of the date hereof. Each undersigned hereby affirms its understanding that Coventry First LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("Coventry") will be relying on the statements and responses which are being provided by the undersigned in this questionnaire, and each undersigned agrees, jointly and severally, to hold Coventry harmless and agrees to indemnify Coventry from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

I UNDERSTAND THAT IT IS A CRIME TO KNOWINGLY PRESENT FALSE, INACCURATE, INCOMPLETE OR MISLEADING INFORMATION TO, OR CONCEAL INFORMATION RELATED TO AN APPLICATION FOR INSURANCE OR FOR A LIFE SETTLEMENT FROM, AN INSURANCE COMPANY OR A LIFE SETTLEMENT PROVIDER FOR THE PURPOSE OF DEFRAUDING SUCH COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF BENEFITS AND CIVIL DAMAGES. I UNDERSTAND THAT COVENTRY FIRST HAS IN PLACE ANTI-FRAUD INITIATIVES DESIGNED TO DETECT AND PREVENT FRAUD, AND MAY REPORT CASES OF SUSPECTED FRAUD TO THE APPROPRIATE LEGAL AND REGULATORY AUTHORITIES OR INSURANCE COMPANIES.

name of insured signature of insured date

name of agent signature of agent date

**Further Details** *(Use this page and attach additional pages as necessary)*

Question number \_\_\_\_\_ details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question number \_\_\_\_\_ details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question number \_\_\_\_\_ details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question number \_\_\_\_\_ details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question number \_\_\_\_\_ details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

