LIFE SETTLEMENT APPLICATION

PERSONAL DATA DATE: _______________

First Insured's Name ____ SSN ___________________________________

Current Address ____ City ___________________________________

State ______ Zip __________ Daytime Phone ________________________ Evening Phone _________________________

Marital Status _______________________ Gender ___________ Date of Birth ___________________________________

US Citizen? Yes ____ No ____ If "No", what country? ________________ Email _________________________________

Second Insured's Name ____ SSN ___________________________________

Current Address ____ City __________________________________

State ________ Zip ___________Daytime Phone _________________________ Evening Phone ____________________

Marital Status _______________________ Gender ____________ Date of Birth __________________________________

US Citizen? Yes ____ No ____ If "No", what country? __________________ Email _______________________________

LIFE INSURANCE POLICY INFORMATION

Insurance Co. ______________________________________ Policy No. ______________________ Issue Date ___________

Face Amount $___________________ Premium Amount $________________ Premium Mode (mo, qtr, annual) __________

Date Last Premium Paid _____________________________ Date Next Premium Due ________________________________

Policy Owner Type? Term ____ Whole Life ____ Univ Life ____ Survivorship ____ VUL ____ Other ___________________

Current Surrender Value $______________________________ Has this policy ever lapsed? __________________________

POLICY OWNER INFORMATION

Name of Policy Owner(s) ____ Date(s) of Birth __________________________

Name of Trustee (if Trust) _______________________________________ Date of Trust _____________________________

Address ____ City _______________________________________

State ________ Zip __________ Daytime Phone __________________________ Evening Phone ____________________

SSN or Tax ID# __________________________ DL# __________________________ Marital Status __________________

U S Citizen? Yes ____ No ____ If "No", what country? ______________________ Email _____________________________

Is this policy subject to liens? Yes ____ No ____ Are there other in-force life insurance policies? Yes ______ No ______

Please list all in-force policies (Company Name, Policy Number) ____

____

Have you/Are you a party to bankruptcy? Yes _____ No _____ (Please attach all discharge papers)

Dependent Children? Yes _____ No _____ If "Yes", list names/ages ____

____

BENEFICIARY INFORMATION

Please list names of all beneficiaries to this policy ____

____

MEDICAL INFORMATION

First Insured General Medical Condition ____

____

Personal Physician _____________________________ Address ____

City ___________________ State ______ Zip ________ Email ____

Phone Number __________________________________ Fax Number ______________________________________

Has Insured used tobacco/nicotine products in past 5 years? Yes _____ No _____

Second Insured General Medical Condition ____

____

Personal Physician ________________________________ Address ____

City _____________________ State ______ Zip ________ Email ____

Phone Number _________________________________ Fax Number ____

Has Insured used tobacco/nicotine products in past 5 years? Yes _____ No _____

The following will be needed to obtain an offer:
-- Copy of the insurance policy or face page
-- In Force Illustrations showing level death benefits to maturity
-- Authorizations to release medical records and policy information (so that we may obtain medical history)
-- If policy owner has ever declared bankruptcy, a copy of the bankruptcy discharge
-- If policy owner has ever been divorced, a copy of the divorce decree

Signature of First Insured ____ Date _________________

Signature of Second Insured ____ Date ________________

Signature of Policy Owner ____ Date ________________

Signature of Witness ____ Date ________________

Printed Name of Witness ____

Authorization for the Release of Information
This authorization complies with the HIPAA Privacy Rule

I authorize my health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf (My Providers) to disclose my entire medical record and any other protected health information, concerning me to Innovative Wealth Partners LLC (The Company), any/all of it's affiliates, agents, employees, and representatives (a listing of which can be supplied upon request). This includes information on the diagnosis or treatment of HIV and sexually transmitted diseases. This also includes the diagnosis and treatment of mental illness, alcohol abuse, drugs and tobacco.

By signing below, I terminate any agreement I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record with our restriction. My protected health information is to be disclosed under this authorization so that the Company may: underwrite my application by making eligibility and risk rating determinations; administer coverage; conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below and copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at: 3722 Illinois Avenue, St. Charles, IL 60174, ATTN: Privacy Official. I understand that a revocation is effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that if I refuse to sign this authorization, the Company will not be able to process my application, or underwrite for coverage and or benefits. I acknowledge I have received a copy of this authorization.

Authorization to Release Policy Information

I HEREBY AUTHORIZE ____________________ the issuer of Policy Number ________________

owned by________________________ and insuring the life of ______________________________,

any information, forms, riders or amendments concerning the Policy. I agree that this authorization is valid until my death or for the maximum period permitted by applicable state law, that a photocopy or facsimile is as valid as the original and that I may request a copy of this authorization. I acknowledge receipt of the Notice of Disclosure of Information.

Signature of Insured Date	Signature of Witness Date
Printed Name	Printed Name
Signature of Owner Date	Signature of Witness Date
Printed Name	Printed Name

INSURANCE AND FINANCIAL SERVICES PROVIDER

Description of Personal Representative’s Authority or Relationship to Proposed Insured/Patient

Proposed Insured / Patient Copy

Authorization for the Release of Information
This authorization complies with the HIPAA Privacy Rule

I authorize my health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf (My Providers) to disclose my entire medical record and any other protected health information, concerning me to Innovative Wealth Partners LLC (The Company), any/all of it's affiliates, agents, employees, and representatives (a listing of which can be supplied upon request). This includes information on the diagnosis or treatment of HIV and sexually transmitted diseases. This also includes the diagnosis and treatment of mental illness, alcohol abuse, drugs and tobacco.

By signing below, I terminate any agreement I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record with our restriction. My protected health information is to be disclosed under this authorization so that the Company may: underwrite my application by making eligibility and risk rating determinations; administer coverage; conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below and copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at: 3722 Illinois Avenue, St. Charles, IL 60174, ATTN: Privacy Official. I understand that a revocation is effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that if I refuse to sign this authorization, the Company will not be able to process my application, or underwrite for coverage and or benefits. I acknowledge I have received a copy of this authorization.

Authorization to Release Policy Information

I HEREBY AUTHORIZE ____________________ the issuer of Policy Number _________________

owned by_________________________ and insuring the life of ______________________________,

any information, forms, riders or amendments concerning the Policy. I agree that this authorization is valid until my death or for the maximum period permitted by applicable state law, that a photocopy or facsimile is as valid as the original and that I may request a copy of this authorization. I acknowledge receipt of the Notice of Disclosure of Information.

_______________________________________ _______________________________________
Signature of Insured Date | Signature of Witness Date

_______________________________________ _______________________________________
Printed Name | Printed Name

_______________________________________ _______________________________________
Signature of Owner Date | Signature of Witness Date

_______________________________________ _______________________________________
Printed Name | Printed Name

INSURANCE AND FINANCIAL SERVICES PROVIDER

____
Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

Company Copy

Date:_________________

____
Insurance Company

____
Address

____

Re: Insured(s):__________________

Policy: # (s):____________________

This letter is to serve as authorization to release any and all information on the above referenced policy including policy values, rider, inforce illustrations and verification of coverage to my current financial advisor and broker of record _____________________.

I agree that this authorization is valid for the maximum period permitted by state law, and that a facsimile or photocopy is as valid as the original.

______________________	______________________
Insured	Owner
______________________	______________________
Print name	Print Name
	______________________
	Title / Relationship
______________________	______________________
Insured #2	Owner #2
______________________	______________________
Print name	Print Name
	______________________
	Title / Relationship