WASHINGTON LIFE SETTLEMENTS 3210 GRACE STREET, NW., SUITE 150, WASHINGTON, D.C. 20007
(888) 777-5432 (202) 333-4100 fax (202) 333-4662 info@washingtonlife.org www.washingtonlife.org

Application for Life Settlement

Insured Information

Marital Status: ☐ Single ☐ Married ☐ Separate ☐ Widowed

Last Name	First Name	Middle Initial	Date of Birth

Address

City	State	Zip

Daytime Telephone Number	Evening Telephone Number
( ) -	( ) -

Do you have a residence in another state? ☐ Yes ☐ No

Please Specify State:	Drivers License Number	State of

Are you a U.S. Citizen? ☐ Yes ☐ No

Social Security Number

Have you ever filed for Bankruptcy? Yes ☐ No ☐
If yes, has it been discharged? Yes ☐ No ☐

Physician Information

Primary Physician	Physician Phone	Physician Fax
	( ) -	( ) -

Address

City	State	Zip

2. Physician/Specialist (what speciality?)	2. Physician Phone	2. Physician Fax
	( ) -	( ) -

3. Physician/Specialist (what speciality?)	3. Physician Phone	3. Physician Fax
	( ) -	( ) -

4. Physician/Specialist (what speciality?)	4. Physician Phone	4. Physician Fax
	( ) -	( ) -

Health Information

Do you smoke? Yes ☐ No ☐ If Yes, How many packs per day ? 1 2 3 4

If hospitalized in the last 5 years, please fill in the following:

Hospital (include city and state)	Condition	Length of Stay
1.		
2.		
3.		

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Health Information (continued)

Hospital (include city and state)	Condition	Length of Stay
4.		

Have you ever had any of the following?

Chest pain/Tightening	☐	Hypertension	☐	Shortness of Breath	☐	TB/Lung Disorder	☐
Heart Attack	☐	Stroke	☐	Skin Disorder	☐	Ulcers	☐
Headaches	☐	Glaucoma	☐	Hepatitis	☐	Cataracts	☐
Allergies or Eczema	☐	Depression	☐	Digestive Problems	☐	Urinary Infections	☐
Blood in Stool	☐	Asthma	☐	Arthritis	☐	Difficulty Hearing	☐
Dizzy Spells	☐	Cancer	☐	Diabetes	☐	Memory Loss	☐

Please provide a description of your current health condition and describe any of the above conditions: (Attach a separate sheet if more space is needed.)

Family History

Have either of your parents had:	Father	Mother	Siblings
Osteoporosis	☐	☐	☐
High Blood Pressure	☐	☐	☐
Epilepsy	☐	☐	☐
Cancer	☐	☐	☐
Heart Attack/Stroke	☐	☐	☐
Diabetes	☐	☐	☐
Asthma/Allergies	☐	☐	☐
Autoimmune disease/arthritis	☐	☐	☐

	If Living		If Deceased	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Please provide any additional descriptions of your current health here:

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2nd Insured : Joint Survivorship or 2nd to Die Policies

NOT APPLICAPLE? SKIP TO PAGE 5

Marital Status: Single ☐ Married ☐ Separate ☐ Widowed ☐

Last Name	First Name	Middle Initial	Date of Birth

Address

City	State	Zip

Daytime Telephone Number	Evening Telephone Number
( ) -	( ) -

Do you have a residence in another state? Yes ☐ No ☐

Please Specify:	Drivers License Number	State of Issue

Are you a U.S. Citizen? Yes ☐ No ☐

Social Security Number
- -

Have you ever filed for Bankruptcy? Yes ☐ No ☐
If yes, has it been discharged? Yes ☐ No ☐

Physician Information

Primary Physician	Physician Phone	Physician Fax
	( ) -	( ) -

Address

City	State	Zip

2. Physician/Specialist (what speciality?)	2. Physician Phone	2. Physician Fax
	( ) -	( ) -

3. Physician/Specialist (what speciality?)	3. Physician Phone	3. Physician Fax
	( ) -	( ) -

4. Physician/Specialist (what speciality?)	4. Physician Phone	4. Physician Fax
	( ) -	( ) -

Health Information

Do you smoke? Yes ☐ No ☐ If Yes, How many packs per day ? 1 2 3 4

If hospitalized in the last 5 years, please fill in the following:

Hospital (include city and state)	Condition	Length of Stay
1.		
2.		
3.		

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2nd Insured : Joint Survivorship or 2nd to Die Policies

NOT APPLICAPLE? SKIP TO PAGE 5

Health Information (continued)

Hospital (include city and state)	Condition	Length of Stay
4.		

Have you ever had any of the following?

Chest pain/Tightening	☐	Hypertension	☐	Shortness of Breath	☐	TB/Lung Disorder	☐
Heart Attack	☐	Stroke	☐	Skin Disorder	☐	Ulcers	☐
Headaches	☐	Glaucoma	☐	Hepatitis	☐	Cataracts	☐
Allergies or Eczema	☐	Depression	☐	Digestive Problems	☐	Urinary Infections	☐
Blood in Stool	☐	Asthma	☐	Arthritis	☐	Difficulty Hearing	☐
Dizzy Spells	☐	Cancer	☐	Diabetes	☐	Memory Loss	☐

Please provide a description of your current health condition and describe any of the above conditions: (Attach a separate sheet if more space is needed.)

Family History

Have either of your parents had:	Father	Mother	Siblings		If Living: Age	If Living: State of Health	If Deceased: Age at Death	If Deceased: Cause of Death
Osteoporosis	☐	☐	☐					
High Blood Pressure	☐	☐	☐	Father				
Epilepsy	☐	☐	☐					
Cancer	☐	☐	☐	Mother				
Heart Attack/Stroke	☐	☐	☐					
Diabetes	☐	☐	☐	Brother(s)				
Asthma/Allergies	☐	☐	☐					
Autoimmune disease/arthritis	☐	☐	☐	Sister(s)				

Please provide any additional descriptions of your current health here:

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Insurance Policy # 1

Policy Number

Policy Type: Individual ☐ Survivorship ☐ Group ☐ Converted ☐

If Individual: Whole Life ☐ Universal Life ☐ Variable Life ☐ Variable UL ☐ Term Life

Insurance Company

Insurance Company Phone ( ) -

Insurance Company Contact

Policy Owner(s)

Last Name (1) First Name Middle Initial

Social Security Number or Tax ID Number

Last Name (2) First Name Middle Initial

Social Security Number or Tax ID Number

If the Owner is a Trust or Corporation please give the name, date instituted and Tax ID number.

Face Amount $

Cash Surrender Value $

Annual Premium Payment $

Policy Issue Date

Name of Policy Beneficiary (1)

Relationship

Name of Policy Beneficiary (2)

Relationship

Insurance Policy #2 (if applicable)

Policy Number

Policy Type: Individual ☐ Survivorship ☐ Group ☐ Converted ☐

If Individual: Whole Life ☐ Universal Life ☐ Variable Life ☐ Variable UL ☐ Term Life

Insurance Company

Insurance Company Phone ( ) -

Insurance Company Contact

Policy Owner(s)

Last Name (1) First Name Middle Initial

Social Security Number or Tax ID Number

Last Name (2) First Name Middle Initial

Social Security Number or Tax ID Number

CIf the Owner is a Trust or Corporation please give the name, date instituted and Tax ID number.

Face Amount $

Cash Surrender Value $

Annual Premium Payment $

Policy Issue Date

Name of Policy Beneficiary (1)

Relationship

Name of Policy Beneficiary (2)

Relationship

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Statement of Acknowledgement and Representation

1. The Applicant warrants and represents that all information contained in this application is true and correct to the best of his/her knowledge, information and belief.
2. The Applicant consents to be examined by a medical professional on behalf of Washington Life Settlements, LLC or its agents and the re-disclosure of any existing medical records. The Applicant consents to the release to Washington Life Settlements, LLC of any and all information that Washington Life Settlements, LLC may request from the Applicant or any third parties. The Applicant will execute any additional documents necessary to allow Washington Life Settlements Brokers, LLC to conduct such examination or to acquire such information.
3. The Applicant herein includes a photocopy of a driver's license or a picture identification and represents and warrants that he/she is in fact that person so identified.
4. The Applicant gives consent to Washington Life Settlement Brokers, LLC and its agents to release this application and all information gathered while processing, including, but not limited to, all medical records, notes, and laboratory reports for the purpose of soliciting the sale of the Applicant's life insurance policy. Applicant acknowledges that Washington Life Settlements, LLC is under no obligation to purchase his or her life insurance policy.

I acknowledge I have read the above and that that I am executing and delivering this authorization freely and unilaterally as of the date written below.

Signature of Seller

X ______________________________

Print Last Name First Name Middle Initial

X ______________________________

Signature of Witness

X ______________________________

Print Last Name

X ______________________________

Do Not Write Below This Line

Todays Date

AGREED and ACCEPTED on ______________ ,

By (Signature of Washington Life Settlements)

X ______________________________

Print Last Name First Name Middle Initial

X ______________________________

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Notice of Disclosure (read before signing) — Initial Each

1. A Life Settlement is a process by which an insurance policy may be sold for cash at a discount of its face value by a person who is at least 65 years of age. ________

2. There may be alternatives to the Life Settlement process, which you may be eligible-including but not limited to: a.) 'Accelerated or Living Benefits Option' offered by the issuer b.) borrowing against the cash value of the policy, or c.), surrendering the policy for cash value. Information on these options should be obtained from your financial advisors. ________

3. Some or all of the proceeds of your Life Settlement may be taxable. Washington Life Settlements, LLC urges you to consult your own attorney and/or tax advisor concerning the transaction. Washington Life Settlements, LLC makes no representations and gives no advice concerning the tax treatment of the proceeds of this transaction. Information on these options should be obtained from your financial advisors. ________

4. The proceeds of a Life Settlement could be available to successful civil claims, bankruptcy trustees, or creditors. ________

5. Some or all of your Life Settlement transaction may strongly affect your eligibility for Medicaid, supplemental Social Security Income or other government benefits and entitlements. Advice on such effects should be obtained from appropriate agencies or obtained from your financial advisors. ________

6. A Life Settlement may be rescinded within thirty (30) days after the agreement is executed or fifteen (15) days after the insured has received payment, whichever is earlier. In order to rescind, the seller must repay the full amount of the settlement received, plus premiums paid to Washington Life Settlements, LLC. In states where statutes or regulations require a longer rescission period, the insured may rescind within that State's regulation period. The right to rescind is subject to law and cannot be waived. ________

7. Purchase funds for the seller's policy will be paid on the date after all of the following have occurred: (a) when the offer has been accepted by the company; (b) the Purchase Agreement has been accepted by the seller and (c) complete assignment of ownership has been acknowledged by the issuing company. ________

8. The insured may be contacted by Washington Life Settlements or its authorized representative for the purpose of determining the insured's health status. ________

9. Payment of Life Settlement Proceeds will be made in a lump sum. Installment payments of Life Settlements are not permitted unless the Life Settlement Company is a licensed insurance company, bank, or the Life Settlement Company has affected the purchase of an annuity or similar product issued by a licensed insurance company or bank. ________

10. The insured may designate a person to whom the accidental death proceeds will be paid by the Life Settlement company, if required by state statute and/or regulation. ________

I acknowledge that I have read and understand the contents of this disclosure and all the information provided is true.

Signature of Seller

X ________________________________

Print Last Name	First Name	Middle Initial
X		

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HIPAA & Insurance Release Form

Authorization for release of Health Information and Insurance Information.

(Release must be completely filled out by patient or power of attorney in order for records to be released)

I hereby authorize Washington Life Settlements to disclose my individual identifiable health and insurance information as described below, which may include information on communicable diseases, chemical or alcohol dependency, laboratory test results, medical history, treatment or other such related information. I understand that I authorize my physician/specialist to release these medical records. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Description of release of information: Any and All.
The reason or purpose of the use and/or disclosure: Insurance Services.

Insurance Company Name	Policy Number

I understand that this authorization will expire 180 days from the date of this authorization unless I otherwise specify by date ________or by an event or ________. I further understand that I may revoke this authorization at any time by Washington Life Settlements in writing at 3210 Grace Street NW, Suite 150, Washington DC 20007. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the revocation.

I have had opportunity to read the contents of this authorization. I confirm that the contents are consistent with my direction

Signature of Patient / Insured

Signature of FIRST Insured
x ____________________

Date of Birth
- -

Print Last Name	First Name	Middle Initial

Social Security Number

Second Insured (if applicable)

Signature of SECOND Insured
x ____________________

Date of Birth
- -

Print Last Name	First Name	Middle Initial

Social Security Number

Policy Owner (If other than insured)

Signature of the Policy owner (*if other than insured*)
x ____________________

Title/Relationship

Print Last Name	First Name	Middle Initial

Social Security Number

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