Please complete and fax all four pages of this application to:
(732)842-6421

For additional information, please call:
Jay Smith
(732)229-6896

Confidential Personal and Insurance Information

After recieving the following four pages of information, we will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign pages two and three.

Personal Data

Name of Insured_____Social Security #_____

Current Address_____

City_____State_____Zip_____County_____

Telephone Number(s) Day_____Evening_____

Date of Birth_____Marital Status_____Male_____Female_____

Dependant Children_____Yes_____No Tobacco Use____Yes____No Type_____

If yes, how much?_____If no, Never____Date Stopped_____

Have you or are you now a party to bankrupcy>____Yes____No If yes, please attach all discharge papers.

If policy owner is different than above

Name of policy owner_____Social Security #_____

Current Address_____

City_____State_____Zip_____County_____

Telephone Number(s) Day_____Evening_____

Life Insurance Policy Information (please enclose a copy of the policy or please complete the following)

Name of Insurance Company_____

Policy number_____

Date Policy was Issued_____Coverage/Face Amount_____

Amount of Premium $_____How frequently is premium paid?_____

Is this a group or individual policy?____Individual____Converted Group

Has an application for insurance on your life ever been declined, rated or modified in any way? ____Yes____No

If yes, provide details_____

_____

Medical History

Please give a brief description of your medical condition (cancer, heart disease, respiratory, diabetes, etc.) List current medications and frequencies.

_____

_____

Name of physician seen for this medical condition

Name of Physician_____Date Last Seen_____

Address_____Telephone#_____

City_____State_____Zip_____

Name of Physician_____Date Last Seen_____

Address_____Telephone#_____

City_____State_____Zip_____

Facility_____Date of Admission_____

Address_____Telephone#_____

City_____State_____Zip_____

Family History: has any parent or sibling ever had diabetes, cancer, high blood pressure, heart disease, kidney disorder or mental illness? If yes, provide details:

_____

_____

How did you hear about this service?_____

_____

Signature of Policy Owner Print Name Date

Authorization for the Release of Medical and/or Insurance Information

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide the bearer and/or its authorized representatives any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the insured. This authorization allows for the disclosure inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all teasting materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources will only use information pursuant to this authorization. Thease funding sources will not release any information to any organization except as may be otherwise lawfully required or as I may further authorize. I agree that a photographic copy or facsimile of this authorization shall be valid as the original. I agree that this authorization shall remain valid for the life time of the undersigned (or last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

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

Disclosure Information For Sellers

You should carefully read the following points and seek additional advice where appropriate.

A life settlement transaction enables the seller to sell his life insurance policy for cash at a reduced amount of its face value.

There are alternatives to the process of selling a life insurance policy, which may be preferable. Some alternatives, where applicable, are (1)borrowing against cash value built up in the life insurance policy, or (2) surrender of the policy. Information on these alternatives should be obtained directly from the insurer that issued the policy.

Portions of the proceeds from a life setlement may or may not be tax free. This transaction is not a viatical settlement and may not fall under P.L. No. 104-191, the Health Insurance Portability and Accountability Act of 1996. Advice should be sought out from a professional tax advisor.

Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the owner.

The proceeds of the sale of the policy may be subject to the claims of creditors.

In accordance with the terms set forth in the Agreement, the sale may be rescinded within fifteen (15) days after the seller recieves payment. In order to rescind, the seller must pay to the purchaser, the full amount of the payment recieved plus premiums, if any paid by the purchaser. If the seller dies within this recission period, the personal representative of the seller shall have the right to rescind this agreement. There will be a $1,000.00 processing fee charged for all rescinded contracts.

Reciept of the sale proceeds may adversely effect the recipient's eligibility for Medicaid, Supplimental Social Security Income or other government benefits or entitlements. Advice should be obtained from the appropriate agency or from a professional advisor.

Funds will be available to seller upon satisfaction of the Conditions Precident as set forth in the agreement.

In the event that the life insurance policy contains a provision for double or additional indemnity for accidental death such additional benefits will be the property of the purchaser.

If the insurance policy has been issued as a joint policy or involves family ridrs or any coverage of a life other than the insured under the policy sold, it is possible that a los of coverage on the other lives may result from seller's sale of the policy. Seller should consult with his or her insurance producer or the company issuing the policy for advice on the proposed sale and the effects it may have in this regard.

I have read and understand the above disclosures.

_____

Seller/Policy Owner