



Policy Evaluation Form
(Please call us about any question in which you are unsure)

Personal Data (All data is held strictly confidential):

Name of Policy Owner: _____

Current Address: _____

City/State/Zip: _____

Telephone Number(s): Day () _____ Evening () _____

Social Security #: _____ Date of Birth: _____

Marital Status: Single___ Married___ Separated___ Divorced___ Dependent Children: Yes ___ No ___

Have you been or are you a now a party to a bankruptcy: Yes ___ No ___

Do you now have a tax lien: Yes ___ No ___

Are you currently receiving any means based entitlement such as Medicaid, Food Stamps or Supplemental Security Income from the Social Security Administration: Yes ___ No ___

IF THE INSURED IS DIFFERENT FROM THE POLICY OWNER, PLEASE COMPLETE THE FOLLOWING:

Name of Insured: _____

Current Address: _____

City/State/Zip: _____

Telephone Number(s): Day () _____ Evening () _____

Social Security #: _____ Date of Birth: _____

Life Insurance Policy Information

TYPE OF POLICY: (CHECK ONE)

Group_____ Individual_____ Converted Group_____ (Date of Conversion_____)

Name of Life Insurance Company: _____

Policy Number: _____ Date Policy was Issued: _____

Coverage/Face Amount: \$ _____

IF THIS IS PART OF A GROUP POLICY, PLEASE GIVE THE FOLLOWING INFORMATION:

Name of Employer: _____

Telephone Number: () _____ Are you still working: Yes ____ No ____

Insured's Medical History

Please give a brief description of medical condition: _____

Date of last appointment with physician: _____ Date of original diagnosis (if any): _____

Name of Physician(s): _____

Address: _____

City/State/Zip: _____

Telephone: () _____ Fax: () _____

If there are any other physicians that have treated you in the last three years, you may attach an additional page including their full name, address, and telephone.

If this is an individual policy, please attach a photocopy of your complete insurance policy including the original life insurance application. If this is a group policy, please attach a copy of your Summary Plan Description including your original life insurance enrollment form. Please also include a photocopy of your Drivers License, and if applicable, Divorce Decree and Bankruptcy discharge.

TERMS, CONDITIONS AND NOTICE OF DISCLOSURE

The Applicant represents that all information contained in this application is true and correct to the best of his/her knowledge. All statements made by the viator, life settler or owner shall be deemed representations and not warranties.

The Applicant consents to be examined by Atlantic Coast Settlements and the re-disclosure of any existing medical records and life insurance policy information. The Applicant consents to the release to Atlantic Coast Settlements of any and all medical and life insurance policy information that Atlantic Coast Settlements may request from the Applicant. The Applicant will execute any documents necessary to allow Atlantic Coast Settlements to conduct such examinations or to acquire such information. The applicant may withdraw his/her consent by written request at any time.

The Applicant herein includes a photocopy of a driver's license or a picture identification and swears and warrants that he/she is in fact that person so identified. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be found guilty of a third degree felony.

In signing this application, the applicant acknowledges that the role of Atlantic Coast Settlements (ACS) is to attempt to locate a buyer for the insurance policy owned by the Applicant, but that ACS makes no representation or guaranty that Applicant's policy will be sold. Further, Applicant acknowledges that ACS is not responsible for any failure on the part of a potential buyer to purchase Applicant's policy on terms offered by a potential buyer through ACS. Applicant acknowledges that ACS is not responsible for the accuracy of any representations made by a potential buyer of Applicant's policy (even if such representations are communicated to the Applicant by ACS), and Applicant will look solely to the potential buyer of Applicant's policy in the event that Applicant believes that a potential buyer has made misrepresentations to Applicant or otherwise failed to perform on purchase offers or other promises.

Signature of Applicant (Current Policy Owner): _____ Date: _____



NOTICE OF DISCLOSURE

1. There may be alternatives to a life or senior settlement contract including, but not limited to, accelerated benefits offered by the issuer of the policy for which you might be eligible. The terms and conditions of such benefits may vary with each individual insurance policy.
2. Some or all of the proceeds of your settlement may be taxable. ACS strongly urges you to consult your own attorney or tax advisor concerning this transaction. ACS makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
4. 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 attorney or tax advisor regarding these potential consequences.
5. You are not required to pay ACS any fees for this service. ACS will be compensated either by the end purchaser of the policy or by a life settlement provider company based on a formula that is a percentage of the face value of the life insurance policy. For example: compensation for a \$100,000 policy could be: $6\% \times \$100,000$ (face value) = \$6,000.00. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.
6. The seller has the right to know, upon written request, the identity of any person who will receive or has received a commission or other form of compensation from the life settlement provider with respect to their life settlement and the amount and terms of such compensation.
7. The seller has the right to rescind a Life Settlement contract up to fifteen (15) calendar days after the receipt of the Life Settlement proceeds by the seller, depending on State regulations. If the insured dies within the rescission period, the Life Settlement contract shall be deemed to have been rescinded, subject to repayment of all Life Settlement proceeds and other payments made by the Life Settlement provider on behalf of the seller or insured, to the Life Settlement provider.
8. Funds will be sent to the seller within 3 business days after the life settlement provider has received the insurer acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

Please sign before a witness.

Signature of Policy Owner

Printed Name

Date

Signature of Witness

Printed Name

Date