TEMPEWICK WEALTH MANAGEMENT LIFE SETTLEMENT CHECKLIST

Please make sure to complete each section in its entirety. Missing information will delay our ability to market your case and ultimately secure a settlement offer. This application contains 7 pages in its entirety.

Items Required:

- ❑ 1. Completed Broker/Agent Data information
- ❑ 2. Completed Insurance Information section
  - ❑ A. Owner
  - ❑ B. Policy Information
  - ❑ C. First Insured
  - ❑ D. Second Insured
- ❑ 3. Completed and signed Authorization for Disclosure of Protected Health Information
- ❑ 4. Completed and signed Policy Release
- ❑ 5. Completed and signed Broker Authorization
- ❑ 6. Current medical records for the past 5 years
- ❑ 7. Current illustration solving for level premium, level death benefit with $1 cash surrender value at maturity. (Please attach.)

1. BROKER/ AGENT DATA

Broker/Agent Name:	Signature:	
Agency Name:		
Address:		
City:	State:	Zip:
E-mail address:	Phone:	Fax:

2-A. INSURANCE INFORMATION/OWNER

Name of Owner		Social Security Number/Tax ID:
Address:		
City:	State:	Zip:
E-mail address:	Phone:	Fax:

2-B. INSURANCE INFORMATION/POLICY INFORMATION

Insurance Company:		
Policy Numbers:		
Policy Type:		
Face Amount:		
Date Issued:		
Rating at Issue:		
If group insurance:		

Insurance Company:		
Policy Numbers:		
Policy Type:		
Face Amount:		
Date Issued:		
Rating at Issue:		
If group insurance:		

2-C. INSURANCE INFORMATION/FIRST INSURED

Name:		Date of Birth:	SS#:
Gender: ❑ Male ❑ Female	Marital Status: ❑ Single ❑ Married ❑ Divorced	Height:	Weight:
Address:			
City:	State:		Zip:
Primary Care Physician Name:		Date of Last Visit:	
Address:	City:	State:	Zip:
E-mail address:	Phone:	Fax:	
Specialist Physician Name:	Specialty:	Date of Last Visit:	
Address:	City:	State:	Zip:
E-mail address:	Phone:	Fax:	

Please provide additional doctor/medical information on page 7.

2-D. INSURANCE INFORMATION/SECOND INSURED

Name:		Date of Birth:	SS#:
Gender: ❑ Male ❑ Female	Marital Status: ❑ Single ❑ Married ❑ Divorced	Height:	Weight:
Address:			
City:	State:		Zip:
Primary Care Physician Name:		Date of Last Visit:	
Address:	City:	State:	Zip:
E-mail address:	Phone:	Fax:	
Specialist Physician Name:	Specialty:	Date of Last Visit:	
Address:	City:	State:	Zip:
E-mail address:	Phone:	Fax:	

Please provide additional doctor/medical information on page 7.

3. Authorization for disclosure—HIPAA Compliant

Tempewick Wealth Management

177 MADISON AVENUE
MORRISTOWN, NJ 07960
973.285.1000/FAX 973.285.1600
EMAIL: ja@tempewick.com

AUTHORIZATION FOR DISCLOSURE - HIPAA Compliant

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider ("Authorized Disclosure") to provide to Tempewick Wealth Management and/or its affiliates, directors, officers, employees, service providers or other representatives noted below ("Tempewick Wealth Management"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Disclosure to release to Tempewick Wealth Management the results of any HIV or AIDS test as well as information relating to any sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed here under will be treated as confidential and will only be used by Tempewick Wealth Management in connection with the decision to purchase, finance, transact a life settlement and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Disclosure by notifying such Authorized Disclosure of my revocation of this authorization in writing and delivery of said revocation by mail or personal delivery at such address designated by Authorized Disclosure; provided that any revocation of this Authorization shall not apply to the extent that (i) the Authorized Disclosure has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care clearing house or health plan covered by privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Disclosure to Tempewick Wealth Management may be redisclosed by Tempewick Wealth Management and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained herein is true, accurate and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a signed copy of this Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Disclosure to rely upon a photostatic or facsimile copy or other reproduction of this Authorization the same as the original.

This Authorization shall remain valid until, and shall expire on the date one year following the date of my death.

AIG-American General / Abacus Settlements, LLC / Allianz / All Financial / Allstate Life of NY / American Mayflower / American National /Applied Capital / AVS Underwriting / AXA / Bankers Life of NY / Banner Life / Berkshire Settlements / Berlin Atlantic Capital / Clearwater Settlements / Columbus Life / Companion of NY / Coventry First / EMSI / Exceptional Risk Advisors / Fair Market Life / Fasano / First Colony Life Genworth Companies / First Equity Benefits / Great West Growth, LLC / Greenwich Life Settlements / Habersham Funding / Hartford / ICS Services / ING Companies / Indianapolis Life / Independent Funding Group, LLC / Insurative Premium Finance (Jersey) Limited / Integrity Settlement Providers / Jefferson Pilot / John Hancock / Legacy Benefits / Liberty Life / Life Equity, LLC / Life Exams / Life Settlement Providers, LLC / Life Settlement Solutions / Life trust, LLC / Lincoln Benefit / Lincoln Life / Living Benefits / Madison Brokerage Corp / Magna Administrative Services / Maple Life Financial / Met Life / Milestone Managers and Providers / Montage Financial Group / National Western Life / Nationwide / Neuma, Inc / New Life Capital Strategies / New York Life / North American / Old Mutual Financial Network / Pacific Life / Peachtree Life Settlements / Phoenix / Portsmouth Settlement / Presidential Life / Principal Financial / Progressive Capital Solutions, LLC / Proverian Capital, LLC / Prudential / Q Capital Strategies / RAI Group / Reliastar Life Ins Co / Reliastar Life of NY / SBLI / Secondary Life Capital, LLC / Senior Settlements / Seven Hills Settlements / 21st Services / Security Life of Denver / Silver Point Capital / Standard Insurance Company / Sun Life / Sun Life of NY / The Ardan Group / Transamerica / United of Omaha / U.S. Financial / US Life / Vespers / ViaSource Funding Group, LLC / West Coast Life / William Penn / Wm. Page & Assoc (Lifeline)

Name of Insured _____ Signature _____

Date of Birth _____ Social Security Number _____ Date _____

4. Policy Release

Authorization for Release of Policy Information

I,_____, hereby authorize, _____
Name of Policy Owner Name of Insurance Company

the issuer of insurance policy number(s) _____

insuring the life/lives of _____and_____

to release any and all policy information to Tempewick Wealth Management, its successors, assigns and authorized representatives. This information may include, but is not limited to, the following information and documents:

a. A copy of the policy, including original application and attached riders
b. Any forms related to the Policy and the rights of the insured and/or owner, including beneficiary designations, assignments, change of ownership, premium payments, policy loans and withdrawals, payment provisions and/or conversion.
c. Current illustrations as may be required
d. Any other information related to my policy

A photocopy of this authorization shall be as valid as the original. This authorization shall remain valid for the life of the undersigned (or the last to survive), 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 by law. I also understand that I may withdraw this consent pursuant to any applicable state statute or regulation.

_____	_____	_____
Name of Policy Owner	Signature	Date
_____	_____	_____
Name of Policy Owner (2)	Signature	Date
_____	_____	_____
Name of Witness (if applicable)	Signature	Date

5. BROKER AUTHORIZATION

BROKER AUTHORIZATION

I/we, the undersigned Policy Owner(s) hereby authorize Tempewick Wealth Management to act as my settlement broker for the purpose of obtaining quotes and facilitating a life and/or viatical settlement for policy number(s)_____ issued by_____ on the life/lives of_____ and _____.
The effective date of this document is the date of signature and this authorization shall be in full force and effect for 180 days from the date of signature. No other settlement broker shall be allowed to transact business on the above referenced policies until the expiration of this authorization.

SIGNATURES

_____	_____	_____
Name of Policy Owner	Signature	Date
_____	_____	_____
Name of Policy Owner (2)	Signature	Date
_____	_____	_____
Name of Witness	Signature	Date

6. CURRENT MEDICAL RECORDS FOR THE PAST 5 YEARS

Client's Name(s):	Soc. Sec. #:

* What physician(s) have you consulted in the past 5 years?

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

Physician(s) name:
Date:
Phone numbers:
Address:

Reason:

* In what hospitals, clinics, etc. have you ever been treated?

Physician(s) name:
Hospital/clinic/etc.:
Phone numbers:
Address:

Reason: Date:

Physician(s) name:
Hospital/clinic/etc.:
Phone numbers:
Address:

Reason: Date:

* Please list all medications