

Settlement Group, Inc.

300 Osborne Street
Saint Marys, GA 31558
Phone: (912)882-0840 Fax: (912)882-0609

HEALTH INFORMATION

Please provide a brief description of Insured's health condition:

What is Insured's primary medical condition? _____

When was Insured's primary medical condition first diagnosed? _____

What are Insured's secondary medical conditions or health concerns? _____

When were these diagnosed? _____

Current/Primary Physician: _____

Address & Phone: _____

Second Physician: _____

Address & Phone: _____

Third Physician _____

Address & Phone: _____

**IF ADDITIONAL PHYSICIANS AND/OR OTHER INFORMATION, ATTACH
ADDITIONAL SHEETS WITH SAME INFORMATION.**

Settlement Group, Inc.

300 Osborne Street
Saint Marys, GA 31558
Phone: (912)882-0840 Fax: (912)882-0609

DISCLOSURE NOTICE TO INSURED AND POLICY OWNER

Settlement Group, Inc. with its principal office located at 300 Osborne St., Saint Marys, GA 31558 hereby advises you of the following information in connection with your Application for a Senior Life Settlement or Viatical Settlement Contract:

1. There are possible alternatives to selling a life insurance policy, including but not limited to, an accelerated death benefit, a living benefit, cash surrender value or loans secured by the life insurance policy. It is recommended that you obtain information from the insurance company(ies) that issued the life insurance policy and/or your advisors regarding the available options.
2. Some or all of the proceeds resulting from the sale of a life insurance policy may be taxable under federal and/or state income and/or other tax laws and you are advised to obtain tax advice from an attorney, financial advisor, accountant and/or professional tax advisor.
3. The sale of a life insurance policy may adversely affect your eligibility for Medicaid and/or any other means-based government programs, benefits or entitlement and may result in an interruption of such public assistance benefits. You are advised to obtain information from the organization responsible for providing these services.
4. The proceeds from the sale of a life insurance policy could be subject to the claims of creditors.
5. You have the right to rescind any contract for the sale of a life insurance policy within fifteen (15) days after you receive the proceeds of the sale, conditioned on the return of such proceeds.
6. You have the right to receive the name, business address and telephone number of the independent third-party escrow agent used in your transaction and may inspect or receive copies of the relevant escrow or trust agreements or documents upon request.

I/We acknowledge that I/we have read and understand the contents of this DISCLOSURE NOTICE. This document may be signed in counterparts.

Signature of Insured (Viator/Life Settlor)

Date

Signature of Policy Owner (Viator/Life Settlor)
(if different from Insured)

Date

Settlement Group, Inc.

300 Osborne Street
Saint Marys, GA 31558
Phone: (912)882-0840 Fax: (912)882-0609

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliant)

I hereby authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider or other institution or person(s) having any records, charts, X-rays, laboratory work or similar information regarding my health, to release and disclose such information as provided in this authorization. I authorize each Authorized Discloser to rely upon a photographic or facsimile copy or other reproduction of this document.

I authorize my Protected Health Information (PHI) to be released and disclosed by each Authorized Discloser under this authorization to Settlement Group, and any of its principals, employees, agents or other authorized representatives and/or their successors, assignees, designees and affiliated entities (collectively, the "Authorized Recipient").

This authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to physician's/nurse's notes; examination summaries; reports and orders; medication and prescription drug records; radiology, pathology and other laboratory or test reports; and other information included in a medical file.

This authorization and all disclosures of my Protected Health Information (PHI) made pursuant to this Authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any and all life insurance policies under which my life is insured, and (2) to verify, track and monitor my health medical status and condition in connection with any and all life insurance policies, under which my life is insured that are sold.

This authorization shall remain valid until, and shall expire on, the date of my death.

I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided that any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the 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, my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and my PHI that is disclosed to the Authorized Recipient 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. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Signature of Patient (Insured)

Printed name of Patient (Insured)

Date signed

Social Security Number of Patient (Insured)

Signature of Witness

Printed name of Witness

Date signed

Settlement Group, Inc.

300 Osborne Street
Saint Marys, GA 31558
Phone: (912)882-0840 Fax: (912)882-0609

AUTHORIZATION FOR RELEASE AND USE 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, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Settlement Group, and/or its authorized representatives or designees, 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 testing 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 and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby expressly authorize such use and disclosure. 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 lifetime of the undersigned (or the 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 there under.

_____ Signature of Insured (Viator/Life Settlor)	_____ Date	_____ Signature of Policy Owner(Viator/Life Settlor)	_____ Date
_____ Printed Name	_____ Date	_____ Printed Name	_____ Date
_____ Signature of Witness	_____ Date	_____ Signature of Witness	_____ Date
_____ Printed Name of Witness	_____ Date	_____ Printed Name of Witness	_____ Date

Settlement Group, Inc.

300 Osborne Street
Saint Marys, GA 31558
Phone: (912)882-0840 Fax: (912)882-0609

OUR PRIVACY POLICY

Settlement Group, Inc. values you as a customer and takes your personal privacy seriously. We will inform you of our policies for collecting, using, securing and sharing nonpublic, personal financial health information the first time we do business with you and, as applicable, every year thereafter that you are our customer.

- We do not sell customer information.
- We do not disclose any nonpublic personal financial or health information about our customers to any unaffiliated entities, except as permitted by law.
- We contractually require any person or organization providing products or services to customers on our behalf to protect the confidentiality of Settlement Group, customer information.
- We afford prospective and former customers the same protection as existing customers with respect to the use of nonpublic personal information.

INFORMATION WE MAY COLLECT

We collect and use information we believe is necessary to administer our business, to advise you about our products and services, and to provide you with customer service. We may collect nonpublic personal information about you from the following sources.

Types of information and how we gather it:

1. From you, on applications or other forms, through telephone or in-person interviews, and through your Settlement Group, representative, such as name, address and Social Security number and previous and current health status.
2. From your transactions with us, our affiliates or others, such as payment and other related information;
3. From non-Settlement Group, related companies, such as insurance related and medical information; and
4. From consumer reporting agencies and other sources, such as your credit history.

HOW WE USE INFORMATION ABOUT YOU

We use customer information to process your transaction requests, ensure proper billing, and generally service your accounts.

Except as stated above and as permitted by law, we do not share nonpublic personal information with third parties. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal rules to guard the privacy of your nonpublic personal information.