Filing at a Glance

Company: Advanced Planning Services, Inc.

Product Name: Viatical Settlement Questionnaire and Disclosures

SERFF Tr Num: APSV-126355388

State: Arkansas

TOI: VS01 Viatical Settlements

SERFF Status: Closed-Approved-Closed

State Tr Num: 43951

Sub-TOI: VS01.000 Viatical Settlements

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Cody Jordan

Disposition Date: 11/04/2009

Date Submitted: 11/02/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/04/2009

Explanation for Other Group Market Type:

State Status Changed: 11/04/2009

Deemer Date:

Created By: Cody Jordan

Submitted By: Cody Jordan

Corresponding Filing Tracking Number:

Filing Description:

Pursuant to the Viatical Settlement Act, Advanced Planning Services, Inc. submits its viatical settlement questionnaire, HIPAA release, policy release, VOC request, and disclosure notices for review and approval by the Department.

If you have any questions or concerns, please do not hesitate to contact me.

Company and Contact

Filing Contact Information

Cody Jordan,
1500 State Street
Suite 220
San Diego, CA 92101

cjordan@apshome.com
541-359-3730 [Phone]

Filing Company Information

Advanced Planning Services, Inc.	CoCode: 524210	State of Domicile: California
1500 State Street	Group Code: 524210	Company Type: Life Settlement Broker
Suite 220	Group Name:	State ID Number: 294088
San Diego, CA 92101	FEIN Number: 33-0835426	
(619) 220-8116 ext. [Phone]		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Advanced Planning Services, Inc.	$20.00	11/03/2009	31749462

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/04/2009	11/04/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	11/03/2009	11/03/2009	Cody Jordan	11/03/2009	11/03/2009

Disposition

Disposition Date: 11/04/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*APSV-126355388*	*State:*	*Arkansas*
Filing Company:	*Advanced Planning Services, Inc.*	*State Tracking Number:*	*43951*
Company Tracking Number:			
TOI:	*VS01 Viatical Settlements*	*Sub-TOI:*	*VS01.000 Viatical Settlements*
Product Name:	*Viatical Settlement Questionnaire and Disclosures*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Consent to Release Medical Records		No
Supporting Document	Escrow Agreement		No
Supporting Document	Physician Statement		No
Supporting Document	Power of Attorney		No
Form	Viatical Settlement Questionnaire		Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/03/2009
Submitted Date	11/03/2009
Respond By Date	12/03/2009

Dear Cody Jordan,

This will acknowledge receipt of the captioned filing.

Objection 1
No Objections
Comment: The filing fee was not included under EFT on this submission. Please refer to Arkansas Rule and Regulation 57 for Arkansas filing fees. The filing fee applicable to this filing is $20.00 per form. If the retaliatory fee is greater than Arkansas, then pay the greater fee. We will hold your filing in a pending status until the fee is received.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/03/2009
Submitted Date	11/03/2009

Dear Linda Bird,

Comments:
Thank you for your speedy response to my submission.

Response 1

Comments: I have submitted a $20 filing fee using SERFF's EFT system.

Related Objection 1

Comment:
The filing fee was not included under EFT on this submission. Please refer to Arkansas Rule and Regulation 57 for Arkansas filing fees. The filing fee applicable to this filing is $20.00 per form. If the retaliatory fee is greater than Arkansas, then pay the greater fee. We will hold your filing in a pending status until the fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any additional requirements or questions, please do not hesitate to contact me.

Sincerely,
Cody Jordan

Form Schedule

Lead Form Number: AEF

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	APSLSQ-ARCL-10/09	Application/ Enrollment Form	Viatical Settlement Questionnaire	Initial			APS Arkansas Life Settlement Questionnaire [2009].pdf

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CHECKLIST FOR LIFE SETTLEMENT QUESTIONNAIRE

For Insured(s)_____

The following items are necessary for the life settlement evaluation and transaction process. Please return the following items completed and signed to APS, Inc. (**Note**: A faxed or scanned copy is acceptable.)

- ❑ **5 Page Data Collection Form** – (Form APSLSQ-Q-06/08)
- ❑ **Agent of Record** (1 Page) – (Form APSLSQ-AoR-06/08)
- ❑ **Agent's Statement** (1 Page) – (Form APSLSQ-AS-06/08)
- ❑ **Authorization for Disclosure of Protected Health Information** (2 Pages) – (Form APSLSQ-HIP-06/08)
- ❑ **Authorization for the Release of Life Insurance Policy Information** (1 Page) – (Form APSLSQ-PR-06/08)
- ❑ **Disclosure Notice and Policy Owner Considerations** (2 Pages) – (Form APSLSQ-ARD-10/09)

Questionnaire Signature Legend

- ✓ Policy Owner's Signature (4 x's)
- X Agent's Signature (1 x)
- ❶ 1st Insured's Signature (2 x's)
- ❷ 2nd Insured's Signature (2 x's)
- * Witness's Signature (8 x's)

- ❑ **Five years of medical records from all attending physicians, current within the previous thirty days of the Questionnaire's submission.** (**Note**: APS, Inc. will be happy to order the medical records for you upon receipt of the completed and signed Questionnaire.)
- ❑ **Copies of the agent's applicable life settlement license.** (**Note**: Some states do not require a life settlement license; please consult your APS, Inc. representative with any questions.)
- ❑ **Complete copy of the life insurance policy. If this is not available immediately, please make a note on the Questionnaire and forward a copy to us as soon as possible.**
- ❑ **If you are the Agent of Record on the policy(ies), please provide a current in-force ledger(s) from the insurance company(ies) showing the following:**

Universal Life — minimum level premium (at the current interest rate) with $1 of cash value at maturity.
Term — conversion illustration to UL showing minimum level premium (at the current interest rate) with $1 of cash value at maturity.
Whole Life — surrender all paid up additions (pay down policy loan, if any); change dividend option to reduce premium; pay interest on any remaining policy loan.

Helpful Case Notes: _____

_____

_____

_____

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LIFE SETTLEMENT QUESTIONNAIRE

INSURED'S INFORMATION

_____ Female ☐ or Male ☐ _____ /_____/_____
Insured's Name Date of Birth

_____ _____ - _____ - _____
Spouse's Name Insured's Social Security Number

_____ _____
Address (*No P.O. Box*) City

_____ _____ (_____) _____ (_____) _____
State Postal Code Home Phone Work Phone

2nd INSURED, *If Applicable*

_____ Sex: Female ☐ Male ☐
Full Name

_____ /_____ /_____ _____ - _____ - _____
Date of Birth Social Security Number

LIFE INSURANCE POLICY INFORMATION *(Please provide for each policy being offered for sale, separate sheet ok)*

_____ _____ _____
Insurance Company Policy Number Issue Date

$_____ $_____ $_____ $_____
Face Value Current Account Value (After Loan is Subtracted) Cash Surrender Value (After Loan is Subtracted) Policy Loans

Policy Lives: Individual ☐ Survivorship ☐ Joint First to Die ☐
Policy Type: Universal ☐ [VUL ☐] Term ☐ Whole Life ☐ Group ☐

$_____ A ☐ SA ☐ Q ☐ M ☐ _____
Premium Paid (Frequency) Next Due Date

$_____ _____
Last Premium Amount Paid Date of Last Premium Paid

OWNER INFORMATION

_____ Policy Owner's Name

_____ State of Residence (If trust owned, list trust domicile)

_____ Address

_____ City

_____ Postal Code

_____ Trust or Corporation Name, & Names of Trustee(s) or 2 Officers (**ATTACH COPIES OF TRUST**)

_____ - _____ - _____ S.S.N./Tax ID Number

(_____) _____ Phone

(_____) _____ Fax

Since this policy has been in force, has owner been a party to a [check all that apply]*:

Civil Suit ☐ Bankruptcy ☐ Judgments ☐ Creditor Liens ☐ Tax Liens ☐ Divorce ☐

**Please explain any checked answers on a separate page and attach all discharge papers.*

BENEFICIARY(IES) INFORMATION (If trust owned, list trust beneficiary(ies))

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State

_____ Postal Code

(_____)_____ Phone Number

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State

_____ Postal Code

(_____)_____ Phone Number

1st INSURED'S MEDICAL INFORMATION

_____

List any specific health or medical conditions (If necessary, attach additional pages).

_____ 1st Insured's Height

_____ 1st Insured's Weight

Have you ever smoked? _____

If yes, how many packs per day? _____

When did you quit? _____

Insured's Physicians (List Primary Care Physician First)*:

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

**Attach additional pages if needed.*

2nd INSURED'S MEDICAL INFORMATION *(If Applicable)*

_____

List any specific health or medical conditions (If necessary, attach additional pages).

_____ 1st Insured's Height

_____ 1st Insured's Weight

Have you ever smoked? _____

If yes, how many packs per day? _____

When did you quit? _____

Insured's Physicians (List Primary Care Physician First)*:

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

_____ Name

_____ Address

_____ Address (cont.)

_____ City

_____ State _____ Postal Code

(_____)_____ Phone Number

_____ Date & Reason of Last Consultation

**Attach additional pages if needed.*

Fraud Notice

Any person who knowingly presents false information in an application for insurance or an application for a viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

PERSONAL ACKNOWLEDGEMENT

I, policy owner and/or insured (hereafter known as "I") represent and warrant to Advanced Planning Services, Inc. (hereafter known as "APS") that all the information contained in this questionnaire is correct and accurate and agree that APS may rely thereon and that I will immediately notify APS of any changes in such information. I further give my consent to APS and its agents to disclose and release this questionnaire and all information gathered about me or my life insurance policy as necessary or desirable for the sole purpose of soliciting the purchase or sale of my life insurance policy. I acknowledge that I am submitting this questionnaire for APS to act as a broker on my behalf. I acknowledge that APS will submit my policy(ies) to various settlement providers to evaluate the purchase of my life insurance policy(ies), and that APS is not liable for any representations, warranties, or misconduct on the part of any settlement provider. I acknowledge I may be contacted by APS or its agents regarding the information contained in this questionnaire. I also acknowledge that neither APS nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible income, estate, or other tax consequences or treatment of the proceeds of this transaction**.**

I/We understand that APS has a duty to find the best offer available for my/our life insurance policy(ies). I understand that APS, at its discretion, may use an auction, bidding, or similar process to facilitate the sale of my policy(ies). I hereby authorize the use of such a process and I understand and agree that any bids that do not conform to the process shall be rejected. I further understand that APS shall disclose its bidding process to me at my request. **Therefore, I /we hereby grant to APS the exclusive right to broker my/our life insurance policy(ies) which may only be terminated upon ninety (90) days prior written notice**. I/We agree that this questionnaire will become part of my/our viatical/life settlement contract if my/our life insurance policy is purchased. I/We agree that all of the information provided in this questionnaire is material and represent and warrant that all of the information is true and correct to the best of my/our knowledge.

Owner's Signature	Owner's Printed Name	Date
Witness	Witness's Printed Name	
1st Insured's Signature (if not the owner)	1st Insured's Printed Name	Date
Witness	Witness's Printed Name	
2nd Insured's Signature	2nd Insured's Printed Name	Date
Witness	Witness's Printed Name	

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AGENT OF RECORD

AGENT OF RECORD INFORMATION

_____ _____
Policy Number(s) Insurance Company

_____ _____
Agent's Name Company

_____
Address (*No P.O. Box*)

_____ _____ (_____) _____
City State Postal Code Phone

(_____) _____ _____
Fax E-Mail Address

I, as the policy owner, name the above-referenced individual as my agent of record for the sale of the aforementioned policy(ies).

✓ _____ _____
Policy Owner's Signature Date

* _____ _____
Witness Witness's Printed Name

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AGENT'S STATEMENT

AGENT'S STATEMENT (To Be Completed by Agent)

_____ _____
Policy Number(s) Insurance Company

_____
Agent's Name

Is the owner an Accredited Investor within the definition of Rule 501 of Regulation D of the Securities Act of 1933 (generally an individual with a net worth exceeding $1,000,000 or an annual income exceeding $200,000; a charitable organization, corporation, or partnership with assets exceeding $5 million; or a trust with assets in excess of $5 million)? Y_____ N_____

Suitability: Have you reviewed the client's financial situation and find a life settlement to be appropriate for this client? Y_____ N_____

Has/Have the policy(ies) been premium financed?* Y_____ N_____

*If yes, does the premium-financing plan include non-recourse financing? Y_____ N_____

Are you, as the Agent of Record, properly licensed to solicit life settlements in the policy owner's state(s)? (Please submit copies of the appropriate license(s)) Y_____ N_____

Are you the original writing agent of the policy? Y_____ N_____

Does the sale of this insurance policy involve replacement insurance? Y_____ N_____

If the policy is sold, state percentage of any commission splits. _____% Agent 1 _____% Agent 2

What is the reason that the owner wants to sell the policy? _____

_____

I, as the named Agent of Record, name Advanced Planning Services, Inc. as the broker of record for the sale of the aforementioned policy(ies). **I hereby acknowledge and affirm that Advanced Planning Services, Inc. be given an exclusive right to be broker of record of said life insurance policy(ies), which may only be terminated upon ninety (90) days prior written notice**.

X_____ _____
Agent's Signature Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual(s), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose my PHI under this authorization to (a) Advanced Planning Services, Inc., its affiliates and any of their directors, officers, employees, agents, independent contractors, service providers or other representatives and (b) any viatical or life settlement company or broker with which Advanced Planning Services, Inc. may transact business (each, an "Authorized Recipient").

3. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure. This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to any Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any Authorized Recipient purchases.

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

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

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition your treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

7. I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy(ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy of this facsimile of this authorization shall be valid as the original.

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, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such 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 and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

***First Insured**:*

❶ _____ _____

Signature of 1st Insured | Signature of Personal Representative of Insured

_____ _____

Print or Type Name of 1st Insured | Description of Personal Representative's Authority: (Power of Attorney, Guardian at Litem or similar status)

_____ _____

Date | Date

* _____ _____

Signature of Witness Date | Print Name of Witness

***Second Insured** (if applicable):*

❷ _____ _____

Signature of 2nd Insured | Signature of Personal Representative of 2nd Insured

_____ _____

Print or Type Name of 2nd Insured | Description of Personal Representative's Authority: (Power of Attorney, Guardian at Litem or similar status)

_____ _____

Date | Date

* _____ _____

Signature of Witness Date | Print Name of Witness

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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

(Please include a separate authorization for each policy)

I hereby authorize _____, the issuer of
Policy Number _____ and/or
Certificate Number _____
owned by _____
and insuring the life or lives of _____ to release and disclose to Advanced Planning Services, Inc. or its authorized agents, a copy of the policy, forms, riders, endorsements, or amendments, illustrations or verification of coverage of this policy. I respectfully request that you reply immediately to any request for information that Advanced Planning Services, Inc., its agents or its designees deliver to you regarding this policy to the extent necessary to assess a potential viatical or life settlement of this policy, including without limitation viatical or life settlement providers and/or underwriters, any and all information pertaining to this policy. I understand that one or more viatical or life settlement providers' funding sources and their 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, and I hereby expressly authorize such use and disclosure. I agree that this authorization is valid for twenty-four (24) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

✓ _____ _____
Signature of Owner Printed Name of Owner

_____ _____
Date Social Security Number

* _____ _____
Signature of Witness Printed Name of Witness

_____
Date

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DISCLOSURE NOTICE AND POLICY OWNER CONSIDERATIONS[†]

1. Possible alternatives to life settlement contracts exist, including, without limitation, accelerated benefits offered by the issuer of the life insurance policy.

2. Some or all of the proceeds of a life settlement contract may be taxable and you should seek assistance from a professional tax advisor.

3. The proceeds from a life settlement contract could be subject to the claims of creditors.

4. The receipt of proceeds from a life settlement contract may adversely affect a recipient's eligibility for public assistance or other government benefits or entitlements and you should seek advice from the appropriate government agencies.

5. The owner has a right to terminate a life settlement contract within fifteen (15) days of the date it is executed by all parties and the owner has received the disclosures required by the Arkansas Life Settlement Act.

6. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period.

7. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

8. The fact that proceeds will be sent to the owner within three (3) business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

9. 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 of a group policy to be forfeited by the owner and you should seek assistance from a professional financial advisor.

10. Advanced Planning Services, Inc. ("APS") and its agents and representatives will be compensated. The provider, not the owner, will compensate APS and its agents and representatives. Brokerage compensation for this life settlement transaction will be calculated based upon thirty-three percent (33%) of the amount by which the gross provider offer exceeds the estimated policy cash surrender value.

[†] This disclosure statement must be presented and signed by all parties prior to signing the viatical settlement provider's viatical settlement application.

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11. The provider will inform the owner of the date by which the funds will be available to the owner and the transmitter of the funds.

12. The Insurance Commissioner requires delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the commissioner to owners during the solicitation process.

13. All medical, financial or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and the provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.

14. The Insurance Commissioner requires providers and brokers to print separate signed fraud warnings on their applications and on their life settlement contracts. This fraud warning is stated below.

15. The insured may be contacted by either the provider or broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to one (1) time every three (3) months if the insured has a life expectancy of more than one (1) year and no more than one (1) time per month if the insured has a life expectancy of one (1) year or less.

16. The provider must disclose any affiliation, if any, between the provider and the issuer of the insurance policy to be settled.

17. The broker represents the owner exclusively, and not the insurer, the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

18. The provider will disclose to the owner with the name, address and telephone number of the provider and the name, business address and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

19. A change of ownership could limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

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Fraud Warning

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Applicant's Acknowledgement of Receipt of a Brochure on Viatical/Life Settlements.

By my signature hereinafter affixed, I/we confirm and acknowledge that I/we acknowledge receipt of a "buyer's guide" describing the process of viatical/life settlements.

Signatures

I/We acknowledge that I/We have read and understand the contents of this DISCLOSURE NOTICE.

✓ _____	_____	_____
Owner's Signature	Owner's Printed Name	Date
* _____	_____	
Witness	Witness's Printed Name	
_____	_____	_____
Provider's Signature	Printed Name	Date

State Insurance Department

Selling Your Life Insurance Policy

Understanding Viatical Settlements

What is a Viatical Settlement?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (*viator*) of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the viatical settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.

2. Find out if your life insurance policy has an *accelerated death benefit*. An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.

Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of viatical settlement providers and brokers that are licensed to do business in the state. Contact them to make sure yours are on the list.

Always Check with Your State

- Contact your state insurance or securities departments to learn about the issues and risks of viatical settlements if:
- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy *and* your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy and immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state insurance department before you make a decision.

1500 State Street, Suite 220
San Diego, CA 92101
(800) 551-8116

PRIMARY INFORMATION

Carrier Name & Policy Number	Policy Owner's Name	Insured's Name

CLOSING DISCLOSURE NOTICE[1]

1. The following is a full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract:

Provider	Offer 1	Offer 2	Offer 3	Offer 4	Offer 5

List any rejected and accepted offers and any counter-offers: *Type Response Here*

Providers not offering: listing of providers that did not offer

2. The following is a written disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract (if blank, then the broker and provider have no affiliations or contractual relationship in connection with the proposed life settlement contract): *Type Response Here*

3. The following is a list of the name of each broker who receives compensation and the amount of compensation received by said broker, which compensation includes anything of value paid or given to the broker in connection with the life settlement contract:

Broker Name	Amount of Compensation Received
	$
	$
	$

[1] This disclosure statement must be presented and signed prior to signing the settlement provider's settlement contract.

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4. The following is a complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. "Gross offer" or "bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees

Provider's Gross Offer:	$*Type Response Here*
Broker's Cumulative Compensation:	$*Type Response Here*
Net Offer to Owner:	$*Type Response Here*

5. The failure to provide the disclosures or rights described herein shall be deemed an Unfair Trade Practice pursuant to §23-81-817.

Signatures

I/We acknowledge that I/We have read and understand the contents of this DISCLOSURE NOTICE.

_____	_____	_____
Owner's Signature	Owner's Printed Name	Date

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO:_____NAIC #_____
Name of Insurance Company

POLICY NUMBER:_____

SUBMITTED FROM:_____
Name of Viatical Settlement Broker/Provider

ADDRESS:_____

TELEPHONE NUMBER:_____

CONTACT:_____TITLE:_____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or Social Security number	*	
Insured's name	*	
Insured's date of birth	*	
Second insured's name (if applicable)	*	
Second insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

_____ _____
Signature of policy owner Date signed

IS THE POLICY IN FORCE? _____YES _____NO

IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

***____TERM ____WHOLE LIFE ____UNIVERSAL LIFE ____VARIABLE LIFE**

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy	*	
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?	*	
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)	*	
Current face amount of policy	*	
Amount of accumulated dividends	*	
Current face amount of riders	*	
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans	*	
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?	*	

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)	*	
Date of last cost of insurance deduction	*	

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

_____ _____

Signature Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____ (date).

Insurance company: _____NAIC # _____

Printed name: _____ Title: _____

Telephone number: _____ Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____ Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____ Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- o Absolute Assignment/Change of Ownership/Viatical Assignment
- o Change of Beneficiary
- o Release of Irrevocable Beneficiary (if applicable)
- o Waiver of Premium Claim Form
- o Disability Waiver of Premium Approval Letter
- o Release of Assignment
- o Change of Death Benefit Option Form (if UL)
- o Allocation Change Form (if Variable)
- o Annual Report
- o Current In Force Illustration

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Consent to Release Medical Records

Bypass Reason: Contained in the Questionnaire Packet Attached

Comments:

Item Status: **Status Date:**

Bypassed - Item: Escrow Agreement

Bypass Reason: As a viatical settlement broker, APS does not use escrow agreement(s)

Comments:

Item Status: **Status Date:**

Bypassed - Item: Physician Statement

Bypass Reason: As a viatical settlement broker, APS does not request physician statement(s)

Comments:

Item Status: **Status Date:**

Bypassed - Item: Power of Attorney

Bypass Reason: As a viatical settlement broker, APS does not request or need a power of attorney

Comments: