

SERFF Tracking Number: INVC-126410702 State: Arkansas
Filing Company: Invescor, Ltd State Tracking Number: 44268
Company Tracking Number:
TOI: VS01 Viatical Settlements Sub-TOI: VS01.000 Viatical Settlements
Product Name: Life Settlement Application, HIPAA IIRF
Project Name/Number: /

Filing at a Glance

Company: Invescor, Ltd

Product Name: Life Settlement Application,
HIPAA IIRF

TOI: VS01 Viatical Settlements

Sub-TOI: VS01.000 Viatical Settlements
Filing Type: Form

SERFF Tr Num: INVC-126410702 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 44268

Co Tr Num:

Author: Lanalee Dupre

Date Submitted: 12/07/2009

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 12/09/2009

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/09/2009

Deemer Date:

Submitted By: Lanalee Dupre

Filing Description:

Being submitted from a life settlement broker:

(1) Life Settlement Application, inv104-2.0-AR;

(2) HIPPA Authorization, inv100-21.0 (containing a statement of variability); and

(3) Insurance Information Request Form, inv102-8.0.

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: Filing not required
in domicile.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/09/2009

Created By: Lanalee Dupre

Corresponding Filing Tracking Number:

Company and Contact

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Filing Contact Information

Lanalee Dupre, duprel@invescor.com
 32901 Middlebelt Rd, Suite 700 248-737-6989 [Phone]
 Farmington Hills, MI 48334

Filing Company Information

Invescor, Ltd CoCode: State of Domicile: Michigan
 32901 Middlebelt Rd, Suite 700 Group Code: Company Type: Life/Viatical
 Settlement Broker
 Farmington Hills, MI 48334 Group Name: State ID Number:
 (248) 737-6989 ext. [Phone] FEIN Number: 38-3077097

Filing Fees

Fee Required? Yes
 Fee Amount: \$60.00
 Retaliatory? No
 Fee Explanation: \$20 per form x 3 forms
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Invescor, Ltd	\$60.00	12/07/2009	32534219

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/09/2009	12/09/2009

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Disposition

Disposition Date: 12/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Consent to Release Medical Records	No	No
Supporting Document	Escrow Agreement	No	No
Supporting Document	Physician Statement	No	No
Supporting Document	Power of Attorney	No	No
Form	Life Settlement Application	Yes	Yes
Form	HIPPA Authorization	Yes	Yes
Form	Insurance Information Request Form	Yes	Yes

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Form Schedule

Lead Form Number: Inv104-2.0-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	inv104-2.0-AR	Application/Enrollment Form	Life Settlement Application	Revised	Replaced Form #: inv104-1.0-AR Previous Filing #:		Life Settlement Application inv104-2 0-AR.pdf
	inv100-21.0	Other	HIPPA Authorization	Revised	Replaced Form #: inv100-10.0-V Previous Filing #:		HIPAA Authorization inv100-21.0.pdf
	inv102-8.0	Other	Insurance Information Request Form	Revised	Replaced Form #: inv102-1.0-V Previous Filing #:		Ins Information Request inv102-8 0.pdf

LIFE SETTLEMENT APPLICATION



Integrity. Trust. Best Execution.

32901 Middlebelt Road, Suite 700
Farmington Hills, MI 48334
Toll Free: (800) 859-6989
Fax: (248) 737-6980
www.invescor.com

LIFE INSURANCE POLICY INFORMATION

Name of Insurance Company _____ Policy Number _____ Policy Issue Date (mm/dd/yy) _____

Face Amount _____ Accumulation Value _____ Total Policy Loan _____ Cash Surrender Value _____

Type of Policy: Convertible Term: Universal Life: Survivorship Universal Life: Variable Universal Life:
Survivorship Variable Universal Life: Whole Life: Survivorship Whole Life: Index Life:

Premium _____ Premium Mode (M, Q, SA, A) _____ Date Last Premium Paid (mm/dd/yy) _____ Date Next Premium Due (mm/dd/yy) _____

Has this policy been premium financed? No Yes : Loan Amount _____

The loan is Recourse or Non-Recourse : _____
(Who is the lender?) _____ (What is the name of the plan?) _____

Name of Beneficiary(ies) _____ Reason for Policy Sale _____

Name of Beneficiary(ies) _____ Other Reason for Policy Sale _____

IF INDIVIDUALLY OWNED, OWNER/SELLER INFORMATION

Name of Policy Owner/Seller _____ Social Security Number _____ Date of Birth (mm/dd/yy) _____ Gender: Male Female

Permanent Residence Address _____ City _____ State _____ Zip Code _____

Marriage Status: Single Married Divorced Widowed Legally Separated

IF TRUST OWNED, OWNER/SELLER INFORMATION

Name of Trust _____ Tax ID Number of Trust _____ Date of Trust (mm/dd/yy) _____ State Law Governing Trust _____

Name of Trustee(s) _____

Trustee's Address _____ City _____ State _____ Zip Code _____

IF CORPORATE OWNED, OWNER/SELLER INFORMATION

Name of Corporation _____ Tax ID Number of Corp. _____ Date of Incorporation (mm/dd/yy) _____ State of Domicile _____

Name of Authorized Officer & Title _____

Corporate Address _____ City _____ State _____ Zip Code _____

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PRIMARY INSURED INFORMATION

Name of Primary Insured _____ Social Security Number _____ Date of Birth (mm/dd/yy) _____ Gender: Male Female

Permanent Residence Address _____ City _____ State _____ Zip Code _____

U.S. Citizen: Yes No

Does the client have any current medical conditions?

No Yes please describe: _____

Is the client taking any medications?

No Yes please provide name of drug and dosage: _____

Has the client been hospitalized or had any surgery in the past 10 years? No Yes please describe: _____

Has the client seen a physician for any medical condition other than routine physicals?

No Yes please describe: _____

Description of Medical History & Condition(s)

PRIMARY INSURED'S PERSONAL PHYSICIAN INFORMATION

Name of Primary Insured's Physician _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

PRIMARY INSURED'S SPECIALIST OR OTHER PHYSICIAN

Name of Primary Insured's Specialist or Other Physician _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

PRIMARY INSURED'S HOSPITALIZATION INFORMATION

Name of Hospital _____ Phone Number _____

Date of Hospitalization (mm/dd/yy) _____ Reason for Hospitalization _____

Address _____ City _____ State _____ Zip Code _____

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SECOND INSURED INFORMATION (IF APPLICABLE)

Name of Second Insured _____ Social Security Number _____ Date of Birth (mm/dd/yy) _____ Gender: Male Female

Permanent Residence Address _____ City _____ State _____ Zip Code _____

U.S. Citizen: Yes No

Does the client have any current medical conditions?

No Yes please describe: _____

Is the client taking any medications?

No Yes please provide name of drug and dosage: _____

Has the client been hospitalized or had any surgery in

the past 10 years? No Yes please describe: _____

Has the client seen a physician for any medical condition other than routine physicals?

No Yes please describe: _____

Description of Medical History & Condition(s)

SECOND INSURED'S PERSONAL PHYSICIAN INFORMATION

Name of Second Insured's Physician _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

SECOND INSURED'S SPECIALIST OR OTHER PHYSICIAN

Name of Second Insured's Specialist or Other Physician _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

SECOND INSURED'S HOSPITALIZATION INFORMATION

Name of Hospital _____ Phone Number _____

Date of Hospitalization (mm/dd/yy) _____ Reason for Hospitalization _____

Address _____ City _____ State _____ Zip Code _____

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Additional Page

Please use this page to list additional physicians, specialists or hospitalization information.

PRIMARY INSURED, ADDITIONAL PHYSICIAN / SPECIALIST OR HOSPITALIZATION INFORMATION

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

SECOND INSURED, ADDITIONAL PHYSICIAN / SPECIALIST OR HOSPITALIZATION INFORMATION

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Name of Additional Physician / Specialist / Hospitalization _____ Phone Number _____

Date of Last Visit (mm/dd/yy) _____ Reason for Last Visit _____

Address _____ City _____ State _____ Zip Code _____

**HIPAA AUTHORIZATION
RELEASE OF HEALTH-RELATED INFORMATION
FOR LIFE SETTLEMENT**



32901 Middlebelt Road, Suite 700
Farmington Hills, MI 48334
Toll Free: (800) 859-6989
Fax: (248) 737-6980
www.invescor.com

This authorization complies with the HIPAA Privacy Rule

Name of Insured/Proposed Insured/Patient (Print)

Date of Birth (mm/dd/yy)

I authorize any health plan, physician, physician practice group, health care professional, nurse, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization, or other health care provider (including any affiliates, directors, officers, employees, agents, contractors, service providers, or representatives thereof) that has provided payment, treatment, or services to me or on my behalf ("My Providers"), to disclose the entire medical record and any other protected health information concerning me to Invescor, Ltd. and its agents, employees, and representatives (the "Authorization"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, including psychotherapy notes. This authorization is given for the purpose of determining whether I am eligible to participate in a life settlement transaction. I authorize Invescor to release any such information to reinsuring companies, or other persons or organizations performing business or legal services for Invescor (the Company(ies)) including, but not limited to life settlement providers (licensed under state law, where required), life expectancy providers, and medical record companies, as identified below. I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Invescor, Ltd. in connection with obtaining a decision to settle one or more life insurance policies under which my life is insured.

[STATEMENT OF VARIABILITY: This space will identify the "Company(ies)" to whom Invescor may disclose an insured's medical information in determining eligibility to participate in or in connection with a life settlement. The list of Company(ies) will vary from time-to-time but will include, and are not limited to, life settlement providers (licensed under state law where required), life expectancy providers, medical record services, and other persons or organizations performing business or legal services for Invescor.]

By my signature below, I acknowledge that any agreement I have made to restrict my protected health information does not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508 (c) (1) (iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at anytime, by sending a written request for revocation to the Company(ies) at Invescor, Ltd., 32901 Middlebelt Road, Suite 700, Farmington Hills, MI 48334, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company(ies) has/have a legal right to contest a claim under an insurance policy or to contest the policy itself. This release form may be used to track on-going health status. I understand that any information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, the Company(ies) may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization.

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 HIPAA.

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 the Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed authorization for further reference.

I specifically authorize and request my insurance company and each of My Providers to rely upon a facsimile, photographic, and/or scanned copy of this signed Authorization.

Signature of Insured/Proposed Insured/Patient or Personal Representative

Date (mm/dd/yy)

Description of Personal representative's Authority or Relationship Patient

Social Security Number of Primary Insured/Patient

Address

City

State

Zip

INSURANCE INFORMATION REQUEST FORM



32901 Middlebelt Road, Suite 700
Farmington Hills, MI 48334
Toll Free: (800) 859-6989
Fax: (248) 737-6980
www.LifeSettleWare.com

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TO: _____ Life Insurance Co.

RE: _____ Insured

POLICY NO: _____

I hereby authorize and request that any insurance company or any other institution or person having custody or control of any insurance records or similar information relating to any individual life insurance policy or a certificate of insurance under a group policy that I own to release any and all such insurance information concerning me to Invescor, Ltd. as promptly as possible. The purpose of the release is to verify coverage, ownership, beneficiary designations, policy values, and to order inforce illustrations.

This letter represents my continuing authorization to you, unless consent is subsequently withdrawn.

Please retain this letter in my files as a record of this authorization and release. Any correspondence with Invescor, Ltd. may be sent to the following address:

Invescor, Ltd.
32901 Middlebelt Road, Suite 700
Farmington Hills, MI 48334
Toll Free: (800) 859-6989
Facsimile: (248) 737-6980

A facsimile, photographic, and/or signed copy of this signed release shall be equally as binding as the original signed document.

Sincerely,

Signature of Policy Owner or Signature of Trustee

Date (mm/dd/yy)

Name of Policy Owner or Name of Trust

Social Security Number of Owner or Tax ID Number of Owner

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Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Consent to Release Medical Records		
Bypass Reason: See form inv100-21.0 attached on the form schedule		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Escrow Agreement		
Bypass Reason: Invescor Ltd is a life settlement broker that does not control the policyowner's funds.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Physician Statement		
Bypass Reason: As the life settlement broker, Invescor does not obtain this document from the policy owner.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Power of Attorney		
Bypass Reason: Invescor Ltd does not obtain a power of attorney from the policy owner.		
Comments:		