

SERFF Tracking Number: CRSU-127144353 State: Arkansas  
Filing Company: Credit Suisse Life Settlements LLC State Tracking Number: 48610  
Company Tracking Number:  
TOI: LS01 Life Settlements Sub-TOI: LS01.000 Life Settlements  
Product Name: Revised HIPAA  
Project Name/Number: /

## Filing at a Glance

Company: Credit Suisse Life Settlements LLC

Product Name: Revised HIPAA

TOI: LS01 Life Settlements

Sub-TOI: LS01.000 Life Settlements

Filing Type: Form

SERFF Tr Num: CRSU-127144353 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 48610

Co Tr Num:

Author: Brian Platt

Date Submitted: 04/28/2011

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 05/03/2011

Disposition Status: Approved-  
Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Filing Status Changed: 05/03/2011

State Status Changed: 05/03/2011

Created By: Brian Platt

Corresponding Filing Tracking Number:

Filing Description:

Credit Suisse Life Settlements LLC would like to amend its previously filed/approved HIPAA.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Overall Rate Impact:

Deemer Date:

Submitted By: Brian Platt

## Company and Contact

### Filing Contact Information

Brian Platt,

11 Madison Avenue

9th Floor

New York, NY 10010

brian.platt@credit-suisse.com

212-325-4576 [Phone]

### Filing Company Information

SERFF Tracking Number: CRSU-127144353 State: Arkansas  
 Filing Company: Credit Suisse Life Settlements LLC State Tracking Number: 48610  
 Company Tracking Number:  
 TOI: LS01 Life Settlements Sub-TOI: LS01.000 Life Settlements  
 Product Name: Revised HIPAA  
 Project Name/Number: /  
 Credit Suisse Life Settlements LLC CoCode: State of Domicile: Delaware  
 11 Madison Avenue Group Code: Company Type:  
 9th Floor Group Name: State ID Number:  
 New York, NY 10010 FEIN Number: 26-0344936  
 (212) 325-4576 ext. [Phone]

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Credit Suisse Life Settlements LLC	\$50.00	04/28/2011	47040714

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/03/2011	05/03/2011

*SERFF Tracking Number:*      *CRSU-127144353*                      *State:*                      *Arkansas*  
*Filing Company:*              *Credit Suisse Life Settlements LLC*              *State Tracking Number:*      *48610*  
*Company Tracking Number:*  
*TOI:*                      *LS01 Life Settlements*                      *Sub-TOI:*                      *LS01.000 Life Settlements*  
*Product Name:*              *Revised HIPAA*  
*Project Name/Number:*      /

## **Disposition**

Disposition Date: 05/03/2011

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		Yes
Supporting Document	Escrow Agreement		No
Supporting Document	Physician Statement		No
Supporting Document	Power of Attorney		No
Supporting Document	Blackline		Yes
Form	HIPAA Release - Entity/Individual as Seller		Yes

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## Form Schedule

### Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AR03A	Certificate	HIPAA Release - Entity/Individual as Seller	Revised	Replaced Form #: AR03A Previous Filing #:		Revised AR 03 - HIPAA.pdf

## **AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

1. **Classes of Persons Authorized to Disclose My Protected Health Information:** I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, licensed professional counselor, licensed clinical professional counselor, licensed psychologist, licensed clinical psychotherapist, social worker, treatment facility and any other type of health care provider or any medical insurer (each, an "Authorized 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 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. This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding my care and treatment and any other information in any Authorized HCP's possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered, 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 any Authorized HCP's possession or control.

2. **Classes of Persons Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my PHI under this authorization to Credit Suisse Securities (Europe) Limited, Credit Suisse Life Settlements LLC and CSSEL Bare Trust and any of their subsidiaries, successors (potential and actual), assigns, beneficiaries and affiliates (collectively, "Credit Suisse"), Wells Fargo Bank, N.A. and any of its service providers, any medical record retrieval company (including, without limitation, Examination Management Services, Inc., MedSave USA, and Record Express, LLC) and any life expectancy underwriters (including, without limitation, AVS, 21<sup>st</sup> Services, Fasano Associates, ISC and EMSI) (each, an "Authorized Recipient"). I also authorize each Authorized Recipient to share the information described herein with (i) potential and actual counterparties to financing, purchasing, hedging and related arrangements, (ii) any life insurance or annuity company and (iii) any other Authorized Recipient (for the avoidance of doubt, such Authorized Recipient in receipt of the PHI shall have the authority to, in turn, share my PHI as if it had received such PHI directly from me).

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, as well as any other information derived from the foregoing, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including without limitation: (i) any life expectancy analysis relating to me; (ii) drug or alcohol abuse; (iii) mental or emotional health conditions, including but not limited to, treatment in a psychiatric hospital; (iv) a sexually transmitted disease; (v) a communicable disease required to be reported to a state health agency; (vi) infection with human immunodeficiency virus (HIV), test results for exposure to HIV infection, or a diagnosis of having ARC (AIDS-related complex) or AIDS caused by HIV infection or another sickness or condition caused by or derived from such HIV infection, or other HIV- related information; (vii) mental retardation; (viii) autism; (ix) a genetic disease, genetic information, or results from genetic tests; (x) a condition that resulted in residence and/or treatment in or by a sanatoria, rest home, nursing home, long term care facility, adult care facility, boarding home, general or speciality hospital, home health agency, recovery care center, rehabilitation hospital, ambulatory care facility, psychiatric adult acute partial hospital, outpatient surgical center, ambulance service or related institution; (xi) development disabilities; (xii) known or suspected cases of tuberculosis, (xiii) end stage renal disease; (xiv) a condition that resulted in treatment at a hospital; and (xv) blindness or visual impairment.

This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (a) to analyze, assess, or evaluate my health or medical condition, or life expectancy, in connection with the potential sale of any life insurance policy under which my life is

insured or in connection with the purchase, maintenance or management of any annuity under which my life is the measuring life, or any sale, assignment or other transfer of such life insurance policy or annuity after its issuance, (b) to enable Credit Suisse to negotiate and enter into relevant financing, hedging and related agreements, (c) to monitor, track or verify my health or medical status and condition, (d) to track mortality trends, (e) to enable Credit Suisse to develop longevity-based financial products and indices that do not personally identify me but upon which payments may be made based upon my mortality or (f) to comply with any judicial, legal or regulatory process.

I acknowledge and understand that Credit Suisse may re-disclose my PHI to its funding sources and their service providers or other representatives, rating agencies and their service providers, and prospective subsequent purchasers of, or investors in, any life insurance policy under which my life is insured.

4. Expiration of Authorization: This Authorization will remain valid for and shall expire twenty-four months from the Effective Date set forth below.

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 Credit Suisse in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at the following address: Credit Suisse Life Finance Group, Eleven Madison Avenue, 9<sup>th</sup> Floor, New York, NY 10010-3529, Attention: Compliance Department; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Recipient 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. I acknowledge and understand that no HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign 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 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 such 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 my future reference.

\_\_\_\_\_  
Insured's Signature:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Effective Date:

SERFF Tracking Number: CRSU-127144353 State: Arkansas  
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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Consent to Release Medical Records		
<b>Comments:</b>		
<b>Attachment:</b> Revised AR 03 - HIPAA.pdf		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Blackline		
<b>Comments:</b> The attached blacklines illustrates the changes that were made against the previously approved form.		
<b>Attachment:</b> AR 03 - HIPAA-Revised AR 03 - HIPAA.pdf		

## **AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

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

1. **Classes of Persons Authorized to Disclose My Protected Health Information:** I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, licensed professional counselor, licensed clinical professional counselor, licensed psychologist, licensed clinical psychotherapist, social worker, treatment facility and any other type of health care provider or any medical insurer (each, an "Authorized 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 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. This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding my care and treatment and any other information in any Authorized HCP's possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered, 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 any Authorized HCP's possession or control.

2. **Classes of Persons Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my PHI under this authorization to Credit Suisse Securities (Europe) Limited, Credit Suisse Life Settlements LLC and CSSEL Bare Trust and any of their subsidiaries, successors (potential and actual), assigns, beneficiaries and affiliates (collectively, "Credit Suisse"), Wells Fargo Bank, N.A. and any of its service providers, any medical record retrieval company (including, without limitation, Examination Management Services, Inc., MedSave USA, and Record Express, LLC) and any life expectancy underwriters (including, without limitation, AVS, 21<sup>st</sup> Services, Fasano Associates, ISC and EMSI) (each, an "Authorized Recipient"). I also authorize each Authorized Recipient to share the information described herein with (i) potential and actual counterparties to financing, purchasing, hedging and related arrangements, (ii) any life insurance or annuity company and (iii) any other Authorized Recipient (for the avoidance of doubt, such Authorized Recipient in receipt of the PHI shall have the authority to, in turn, share my PHI as if it had received such PHI directly from me).

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, as well as any other information derived from the foregoing, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including without limitation: (i) any life expectancy analysis relating to me; (ii) drug or alcohol abuse; (iii) mental or emotional health conditions, including but not limited to, treatment in a psychiatric hospital; (iv) a sexually transmitted disease; (v) a communicable disease required to be reported to a state health agency; (vi) infection with human immunodeficiency virus (HIV), test results for exposure to HIV infection, or a diagnosis of having ARC (AIDS-related complex) or AIDS caused by HIV infection or another sickness or condition caused by or derived from such HIV infection, or other HIV- related information; (vii) mental retardation; (viii) autism; (ix) a genetic disease, genetic information, or results from genetic tests; (x) a condition that resulted in residence and/or treatment in or by a sanatoria, rest home, nursing home, long term care facility, adult care facility, boarding home, general or speciality hospital, home health agency, recovery care center, rehabilitation hospital, ambulatory care facility, psychiatric adult acute partial hospital, outpatient surgical center, ambulance service or related institution; (xi) development disabilities; (xii) known or suspected cases of tuberculosis, (xiii) end stage renal disease; (xiv) a condition that resulted in treatment at a hospital; and (xv) blindness or visual impairment.

This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (a) to analyze, assess, or evaluate my health or medical condition, or life expectancy, in connection with the potential sale of any life insurance policy under which my life is

insured or in connection with the purchase, maintenance or management of any annuity under which my life is the measuring life, or any sale, assignment or other transfer of such life insurance policy or annuity after its issuance, (b) to enable Credit Suisse to negotiate and enter into relevant financing, hedging and related agreements, (c) to monitor, track or verify my health or medical status and condition, (d) to track mortality trends, (e) to enable Credit Suisse to develop longevity-based financial products and indices that do not personally identify me but upon which payments may be made based upon my mortality or (f) to comply with any judicial, legal or regulatory process.

I acknowledge and understand that Credit Suisse may re-disclose my PHI to its funding sources and their service providers or other representatives, rating agencies and their service providers, and prospective subsequent purchasers of, or investors in, any life insurance policy under which my life is insured.

4. Expiration of Authorization: This Authorization will remain valid for and shall expire twenty-four months from the Effective Date set forth below.

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 Credit Suisse in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at the following address: Credit Suisse Life Finance Group, Eleven Madison Avenue, 9<sup>th</sup> Floor, New York, NY 10010-3529, Attention: Compliance Department; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Recipient 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. I acknowledge and understand that no HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign 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 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 such 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 my future reference.

\_\_\_\_\_  
Insured's Signature:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Effective Date:

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2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Credit Suisse Securities (Europe) Limited, Credit Suisse Life Settlements LLC and CSSEL Bare Trust and any of their subsidiaries, successors (potential and actual), assigns, beneficiaries and affiliates (collectively, "Credit Suisse"), Wells Fargo Bank, N.A. and any of its service providers, any medical record retrieval company (including, without limitation, Examination Management Services, Inc., MedSave USA, and Record Express, LLC) and any life expectancy underwriters (including, without limitation, AVS, 21<sup>st</sup> Services, Fasano Associates, ISC and EMSI) (each, an "Authorized Recipient"). I also authorize each Authorized Recipient to share the information described herein with (i) potential and actual counterparties to financing, purchasing, hedging and related arrangements, (ii) any life insurance or annuity company and (iii) any other Authorized Recipient (for the avoidance of doubt, such Authorized Recipient in receipt of the PHI shall have the authority to, in turn, share my PHI as if it had received such PHI directly from me).

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\_\_\_\_\_  
Insured's Signature:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Effective Date:

Document comparison by Workshare Professional on Tuesday, April 12, 2011  
10:01:03 AM

Input:	
Document 1 ID	file:///K:/_RestrictedAccess/Structuring Execution/E. Logan/Licensed States/Form Filings/Revised State forms for Stephanie/revised HIPAAs/AR 03 - HIPAA.doc
Description	AR 03 - HIPAA
Document 2 ID	file:///K:/_RestrictedAccess/Structuring Execution/E. Logan/Licensed States/Form Filings/Revised State forms for Stephanie/revised HIPAAs/Revised AR 03 - HIPAA.doc
Description	Revised AR 03 - HIPAA
Rendering set	standard

Legend:	
<u>Insertion</u>	
<del>Deletion</del>	
<del>Moved from</del>	
<u>Moved to</u>	
Style change	
Format change	
<del>Moved deletion</del>	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
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Deletions	0
Moved from	0
Moved to	0
Style change	0
Format changed	0
Total changes	1