

<i>SERFF Tracking Number:</i>	<i>LGCB-127308223</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Legacy Benefits, LLC</i>	<i>State Tracking Number:</i>	<i>49223</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>VS01 Viatical Settlements</i>	<i>Sub-TOI:</i>	<i>VS01.000 Viatical Settlements</i>
<i>Product Name:</i>	<i>New Form Filing</i>		
<i>Project Name/Number:</i>	<i>Arkansas - New Forms/</i>		

Filing at a Glance

Company: Legacy Benefits, LLC

Product Name: New Form Filing

TOI: VS01 Viatical Settlements

Sub-TOI: VS01.000 Viatical Settlements

Filing Type: Form

SERFF Tr Num: LGCB-127308223 State: Arkansas

SERFF Status: Closed-Approved-Closed
State Tr Num: 49223

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Linda Bird

Author: Jennifer Covell

Disposition Date: 07/11/2011

Date Submitted: 07/05/2011

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: 07/05/2011

State Filing Description:

General Information

Project Name: Arkansas - New Forms

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 07/11/2011

State Status Changed: 07/11/2011

Created By: Jennifer Covell

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jennifer Covell

Filing Description:

Filing revised and new forms to be used in life settlement transactions. Of the documents being filed, only AR.10 (Offer Letter) will be used to replace the previously approved version of this document. A redlined version has been uploaded to the Supporting Document tab to show the changes from the prior version.

Company and Contact

Filing Contact Information

Jennifer Covell, Director of Closing & Client Services

jcovell@legacybenefits.com

Legacy Benefits, LLC

800-875-1000 [Phone] 230 [Ext]

SERFF Tracking Number: LGCB-127308223 *State:* Arkansas
Filing Company: Legacy Benefits, LLC *State Tracking Number:* 49223
Company Tracking Number:
TOI: VS01 Viatical Settlements *Sub-TOI:* VS01.000 Viatical Settlements
Product Name: New Form Filing
Project Name/Number: Arkansas - New Forms/

Empire State Building 646-878-2915 [FAX]
 350 Fifth Avenue, Suite 4320
 New York, NY 10118

Filing Company Information

Legacy Benefits, LLC	CoCode: 1	State of Domicile: New York
350 Fifth Avenue	Group Code:	Company Type: limited liability company
Suite 4320	Group Name:	State ID Number:
new york, NY 10118	FEIN Number: 26-1191310	
(212) 643-1190 ext. [Phone]		

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Legacy Benefits, LLC	\$0.00	07/05/2011	
Legacy Benefits, LLC	\$200.00	07/05/2011	49415694

SERFF Tracking Number: LGCB-127308223

State: Arkansas

Filing Company: Legacy Benefits, LLC

State Tracking Number: 49223

Company Tracking Number:

TOI: VS01 Viatical Settlements

Sub-TOI: VS01.000 Viatical Settlements

Product Name: New Form Filing

Project Name/Number: Arkansas - New Forms/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/11/2011	07/11/2011

SERFF Tracking Number: LGCB-127308223

State: Arkansas

Filing Company: Legacy Benefits, LLC

State Tracking Number: 49223

Company Tracking Number:

TOI: VS01 Viatical Settlements

Sub-TOI: VS01.000 Viatical Settlements

Product Name: New Form Filing

Project Name/Number: Arkansas - New Forms/

Disposition

Disposition Date: 07/11/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *LGCB-127308223* State: *Arkansas*
 Filing Company: *Legacy Benefits, LLC* State Tracking Number: *49223*
 Company Tracking Number:
 TOI: *VS01 Viatical Settlements* Sub-TOI: *VS01.000 Viatical Settlements*
 Product Name: *New Form Filing*
 Project Name/Number: *Arkansas - New Forms/*

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
Supporting Document	OR.10 - Offer Letter (redlined version)	Yes	Yes
Form	Offer Letter	Yes	Yes
Form	Insurance Release Form (owner only)	Yes	Yes
Form	Supplemental Application	Yes	Yes
Form	Cooperation Authorization	Yes	Yes

SERFF Tracking Number: LGCB-127308223 State: Arkansas
 Filing Company: Legacy Benefits, LLC State Tracking Number: 49223
 Company Tracking Number:
 TOI: VS01 Viatical Settlements Sub-TOI: VS01.000 Viatical Settlements
 Product Name: New Form Filing
 Project Name/Number: Arkansas - New Forms/

Form Schedule

Lead Form Number: AR.10

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AR.10	Other	Offer Letter	Initial			Legacy Benefits, LLC - AR.10 - Offer Letter.pdf
	AR.20a	Other	Insurance Release Form (owner only)	Initial			Legacy Benefits, LLC - AR.20a - Insurance Release Form.pdf
	AR.25	Other	Supplemental Application	Initial			Legacy Benefits, LLC - AR.25 - Supplemental Application.pdf
	AR.26	Other	Cooperation Authorization	Initial			Legacy Benefits, LLC - AR.26 - Cooperation Authorization.pdf

July 5, 2011

POLICY OWNER NAME
ADDRESS
CITY, STATE ZIP CODE

Dear POLICY OWNER:

Legacy Benefits, LLC ("LEGACY") is hereby offering to purchase your life insurance policy issued by NAME OF INSURANCE COMPANY ("INSURANCE COMPANY"), policy number POLICY NUMBER with a face amount of \$ FACE AMOUNT ("POLICY"), insuring the life of INSURED NAME, for the amount of \$PURCHASE PRICE NUMERICAL (PURCHASE PRICE – WRITTEN AMOUNT) dollars and 00/100).

In order to close the transaction, we are enclosing herewith the following documents to be completed, initialed, signed, witnessed and/or notarized by the designated party or parties as indicated below:

1. **Life Settlement Purchase Agreement and Irrevocable and Absolute Assignment of Life Insurance Policy** to be initialed on each page and signed by you and the insured (if applicable) in the presence of a notary public.
2. **Life Settlement Escrow Agreement** to be signed by you.
3. **Seller's Disbursement Instructions** to be completed and signed by you.
4. **Beneficiary's Absolute Assignment and Waiver of Claim** to be signed by each current beneficiary in the presence of a notary public.
5. **[If selling policy owner is an individual include: Consent of Policy Owner's Spouse**, if you are married, to be signed by your spouse in the presence of a notary public.]
6. **Application and Supplemental Application Forms** to be completed and signed by you, and, if applicable, the insured, and witnessed by another party.
7. **Designation of Contacts** naming one individual as the primary designee who may be contacted quarterly, as well as three alternates, to be completed and signed by the insured. The primary designee will be responsible for providing us or our designee with a certified copy of the certificate of death upon the passing of the insured.
8. **Primary Designee Acknowledgment of Responsibility** form to be completed and signed by the primary designee as identified in the Designation

of Contacts (see above item) and witnessed by another party.

9. **Life Insurance Information Release** form to be completed and signed by you and the insured and witnessed by another party.
10. **Authorization for Disclosure of Medical Information** to be completed and signed by the insured and witnessed by another party.
11. **Limited Power of Attorney Form** to be signed by the insured in the presence of a notary public.
12. **Insured's Continuing Cooperation Authorization** to be signed by the insured on the first page in the presence of a notary public
13. **Physician's Competency Letter** to be completed by your primary care physician. **[ONLY SEND OUT IF SELLING POLICY OWNER IS THE INSURED UNDER POLICY OR IF THE INSURED IS THE ONLY INDIVIDUAL SIGNING ON BEHALF OF OWNER.]**
14. **Information Booklet & Notice of Disclosure** to be signed and dated by you.
15. **Acknowledgement Form for Viatical Settlement** to be signed by you and witnessed by another party.
16. **Life Settlement Commission Disclosure Statement** to be initialed and signed by you in the presence of a notary public.
17. **Verification of Coverage Form** to be signed by you (on the last page).
18. **[Insured's Consent To Annuity Purchase form** to be completed and signed by Insured and witnessed by two additional individuals. **[ONLY IF INCLUDED IN CLOSING PACKAGE.]**

This offer and the funding of this transaction are contingent upon receipt and approval by LEGACY, to its full satisfaction, of the following documents:

- (A) A currently dated LEGACY Verification of Coverage form pertaining to the POLICY, which sets forth the names of the POLICY beneficiary(ies), signed by you on the last page (see above) and completed and signed by a home office representative of the INSURANCE COMPANY;
- (B) Forms of Identification:
 1. If you are an individual, copies of two (2) forms of government-issued identification for each of you and the insured, plus a W-9 form that has



Legacy Benefits, LLC
Empire State Building
350 Fifth Avenue, Suite 4320
New York, NY 10118
T 800.875.1000
T 212.643.1190
F 212.643.1180
legacybenefits.com

been completed and signed by you (NOTE: the insured's IDs must include his/her date of birth, social security number, current residence and a photo of him or her and your IDs must include your social security number, current residence and a photo of you);

- 2. If you are signing on behalf of a trust or other entity, copies of one form of government-issued identification for you (your ID must include a photo of you), two (2) forms of government-issued identification for the insured (NOTE: the insured's IDs must include his/her date of birth, social security number, current residence and a photo of him/her), plus a W-9 for the trust or entity that has been completed and signed by you.

- (C) All pages of a currently dated in-force illustration pertaining to the POLICY and conforming to LEGACY's requirements;
- (D) The original POLICY contract including the original application for life insurance and all amendments, riders and attachments thereto; and
- (E) Three sets of INSURANCE COMPANY's Change of Ownership and Change of Beneficiary forms to be signed by you and witnessed by another party (PLEASE DO NOT DATE THESE FORMS).

Also enclosed is the Buyer's Guide – Selling Your Life Insurance Policy for your review.

LEGACY has the right to withdraw this conditional offer on Deadline at 5:00 p.m. Eastern Standard Time if all of the documents listed above have not been properly completed, executed and delivered to LEGACY on or before this date. LEGACY further reserves the right to require additional documents or information following this date.

We expect to complete this transaction and have the funds released to you following receipt of written confirmation from INSURANCE COMPANY that the new owner and beneficiary has been properly recorded in its records.

If you have any additional questions, please feel free to call.

Sincerely,

LEGACY BENEFITS, LLC

By: _____
NAME
TITLE

Enclosures



Legacy Benefits, LLC
 Empire State Building
 350 Fifth Avenue, Suite 4320
 New York, NY 10118
 T 800.875.1000
 T 212.643.1190
 F 212.643.1180
 legacybenefits.com

LIFE INSURANCE INFORMATION RELEASE FORM

_____ hereby authorizes _____,
 Policy Owner Insurance Company

the issuer of life insurance policy number _____ (the "Policy") insuring the life of
 Policy Number

_____, to release to Legacy Benefits, LLC, its financing sources and/or
 Name of Insured

entities, special purpose entities, related trusts or its authorized representatives (the

"Requestor"), any and all information concerning the Policy by telephone, facsimile, email, post or
 parcel service, or any other method requested by the Requestor.

Policy Owner Signature/Title

Date

Type or Print Name

EIN/Social Security Number

Policy Owner Signature/Title

Date

Type or Print Name

EIN/Social Security Number

SIGNATURES WITNESSED BY:

Witness Signature

Type or Print Name

Street Address (Apt. No.)

City, State, Zip Code

SUPPLEMENTAL APPLICATION

Insured:	«Insured_1»
Seller:	«Owner_Company» or «Owner_1»
Policy Number:	«Policy_Number»
Insurer:	«Insurer»

Definitions:

- I. "Entity" means a trust, corporation, partnership, limited liability company or other such organization.
- II. "Person" means either an individual or an entity.
- III. "Organizational Documents" means the following.
 - a. Trust agreement.
 - b. Certificate of formation.
 - c. Bylaws.
 - d. Shareholders agreement.
 - e. Partnership agreement.
 - f. Operating agreement.

1. Has another Person ever owned the Policy besides «Insured_1» and «Insured_1»'s family?

- Yes
 No

a. If Yes, please specify.

b. If Yes, please describe the relationship between any prior owner(s) and «Insured_1».

c. If Yes, please provide proof of the chain of ownership transfers between all of the prior owners. Such proof may include the following.

- i. Change forms acknowledged by Insurer.
- ii. Purchase agreement between prior owner(s) and the Seller.
- iii. Documents executed as part of the transfer.
- iv. Organizational Documents of the prior owner(s).

2. Has another Person had an ownership interest in the Policy besides «Insured_1» and «Insured_1»'s family?

- Yes
- No

a. If Yes, please specify.

b. If Yes, please describe the relationship between such prior owner(s) and «Insured_1».

c. If Yes, please provide proof of ownership transfers between all of the prior owners. For types of proof, see item 1(c) above.

3. When the Policy was issued, did the Seller intend to resell it (either immediately or at some time in the future)?

- Yes
- No

If Yes, please describe the nature of the plans. Please include the following.

- i. The name of the intended purchaser.
- ii. The price discussed or agreed upon.

4. When the Policy was issued, did the Insured intend to resell it at some time in the future (whether immediately or some time in the future)?

- Yes
- No

If Yes, please describe the nature of the plans. Please include the following.

- i. The name of the intended purchaser.
- ii. The price discussed or agreed upon.

5. Have the Insured or Seller been offered or provided any incentives in connection with obtaining the Policy?

- Yes
- No

Incentives may include the following.

- i. Cash.
- ii. Other items of value.

If Yes, please provide the value of the item(s) offered _____.

If Yes, please describe the item(s) offered _____.

6. Please provide proof of payment of all premium payments made to the Insurer in the last 12 months if either of the following apply to the Policy.

- a. It is three (3) years old or less
- b. Its face amount is \$1,000,000 or more.

Such proof may include the following.

- a. Wire confirmations from the payor's account.
- b. Copies of the front and back of cancelled checks.

7. If the Policy is owned by an entity, please provide proof of the source of funds provided for the premium payments if either of the following apply.

- a. It is three years old or less.
- b. It has a face amount of \$1,000,000 or more.

8. The Insured must provide proof of his or her net worth at the time that the Policy application was made.

- a. The amount of net worth shown shall be equal to the lesser of the following.
 - i. The face amount of all life insurance that was in force on the Insured's life at the time.
 - ii. The Insured's stated net worth on the Policy application.
- b. Proof of the Insured's net worth must show assets held as follows.
 - i. In Insured's name.
 - ii. In Insured's spouse's name.
 - iii. In an entity in which Insured has an interest. For such assets, please provide the following.
 - 1. Proof of Insured's interest. This may include the following.
 - a. Organizational Documents.
 - b. Agreements.
 - 2. Proof of Insured's percentage interest.
- c. Such proof may include the following.
 - i. Bank account statements.
 - ii. Brokerage account statements.
 - iii. Income tax returns.

Remainder of page intentionally left blank.



Legacy Benefits, LLC
Empire State Building
350 Fifth Avenue, Suite 4320
New York, NY 10118
T 800.875.1000
T 212.643.1190
F 212.643.1180
legacybenefits.com

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR SETTLEMENT CONTRACT IS GUILTY OF A CRIME. UPON CONVICTION, THE PERSON MAY BE SUBJECT TO FINES, CONFINEMENT IN PRISON OR BOTH.

«Owner_1»'s Signature
«Owner_1_Title» [if entity]
«Owner_Company» [if entity]

Date

Witness Signature

Witness Address

Print Witness Name

City/State/Zip

«Insured_1»'s Signature

Date

Witness Signature

Witness Address

Print Witness Name

City/State/Zip

INSURED'S CONTINUING COOPERATION AUTHORIZATION

Insured:	«Insured_1»
Seller:	«Owner_Company» or «Owner_1»
Policy Number:	«Policy_Number»
Insurer:	«Insurer»

Following the purchase of the above life insurance policy (the "Policy"), upon the request of Legacy Benefits, LLC or any respective successor and assign or future owner (collectively, the "Then Current Owner") of the Policy, I, «Insured_1» agree to execute releases and authorizations. I further agree to do act as may be necessary from time to time, including permitting or authorizing the Then Current Owner to obtain current information about me.

Following receipt of an Insured's Continuing Authorization for Disclosure of Protected Health Information (Appendix A) and an Information Sheet (Appendix B) from the Then Current Owner, I, «Insured_1» agree to complete and promptly return these documents to the Then Current Owner. I understand that this request will be made no more than once annually.

This is an irrevocable authorization. I have freely and voluntarily executed this document. Copies of it shall suffice in lieu of an original. The Seller understands and has acknowledged that the sale of the Policy is contingent on the execution of this document.

Insured's Signature _____	Date _____
Insured's Printed Name _____	

State Of _____:}	
}	
County Of _____:}	
<p>On the _____, 20__, before me, the undersigned, a Notary Public in and for said State, personally appeared «Insured_1», personally known to me on the basis of satisfactory evidence to be the individual whose name is subscribed on the within Acknowledgment as the Insured and acknowledged to me that he/she executed the same, and that by his/her signature on the Acknowledgement, the individual executed the instrument.</p> <p>IN WITNESS WHEREOF I have hereunto set my hand and official seal.</p> <p style="text-align: right; margin-right: 100px;">_____ Notary Public/Commissioner of Oath My Commission Expires: _____</p>	
(SEAL)	

Appendix A

**INSURED'S CONTINUING AUTHORIZATION FOR THE RELEASE OF
HEALTH INFORMATION**

Insured: «Insured_1»
Date of Birth: «Insured_1_DOB»
Social Security Number: «Insured_1_SSN»
Policy Number: «Policy_Number»
Insurer: «Insurer»

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, clinic, medical center, hospital and/or any other health care provider (each, an "Authorized Discloser") to provide to Legacy Benefits, LLC and/or any of its affiliates, officers, employees, agents, independent contractors, service providers, financing sources and/or entities or other authorized representatives and/or any of their successors or assigns (collectively, "Legacy"), and to **Broker**, **Insurer** and **Service** (collectively, the "Authorized Recipients"), any and all information or records, including but not limited to any charts, x-rays and lab tests, as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to the Authorized Recipients the results of any HIV or AIDS tests as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations, treatment and/or information.

I understand that all information disclosed hereunder will be treated as confidential and will only be used by the Authorized Recipients (1) in connection with Legacy's decision to purchase and/or maintain one or more life insurance policies under which my life is insured and (2) to verify, track and monitor my health status and condition in connection with any and all life insurance policies under which my life is insured that Legacy purchases. I further understand that I am not required to sign this Authorization For Disclosure of Health Information ("Authorization") in order to obtain health care benefits (treatment, payment or enrollment).

I acknowledge and understand that I have the right to revoke this Authorization at 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 (1) Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii) if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care 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, any of my medical information disclosed by Authorized Discloser to the Authorized Recipients may be redisclosed by the Authorized Recipients and may no longer be protected by the HIPAA Privacy Regulations.

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

I specifically authorize and request each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this Authorization. This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

Signatures on the following page.

Appendix B

Insured: «Insured_1»
 Policy Number: «Policy_Number»

Information Sheet: Please complete the below and return to **[Insert Address]**.

Insured Details:

Primary Address _____
City _____ State _____ Zip _____
Home Telephone _____
Work Telephone _____
Email Address _____

Primary Designated Contact's Details:

Name of Primary Contact _____
Address _____
City _____ State _____ Zip _____
Home Telephone _____
Work Telephone _____
Email Address _____
Relationship to Insured _____

Alternate Designated Contacts' Details:

Name of Alternate Contact _____
Address _____
City _____ State _____ Zip _____
Home Telephone _____
Work Telephone _____
Email Address _____
Relationship to Insured _____

Name of Alternate Contact _____
Address _____
City _____ State _____ Zip _____
Home Telephone _____
Work Telephone _____
Email Address _____
Relationship to Insured _____

Name of Alternate Contact _____
 Address _____
 City _____ State _____ Zip _____
 Home Telephone _____
 Work Telephone _____
 Email Address _____
 Relationship to Insured _____

Current Primary Physician's Details:

Insured's Primary Physician: _____
 Physician's Full Address: _____
 City and State: _____
 Physician's Telephone Number: _____

Please provide the requested information below for all Physicians seen within the past year, if applicable.

Physician's Name: _____
 Physician's Full Address: _____
 City _____ State _____ Zip _____
 Physician's Telephone Number: _____
 Date(s) of Visit(s): _____
 Reason(s) for Visit(s): _____

Physician's Name: _____
 Physician's Full Address: _____
 City _____ State _____ Zip _____
 Physician's Telephone Number: _____
 Date(s) of Visit(s): _____
 Reason(s) for Visit(s): _____

Physician's Name: _____
 Physician's Full Address: _____
 City _____ State _____ Zip _____
 Physician's Telephone Number: _____
 Date(s) of Visit(s): _____
 Reason(s) for Visit(s): _____

Please list any new developments in health that have occurred within the past year, if applicable

Please list any new prescription or non prescription medications you have begun taking within the last year, if applicable

I certify that to the best of my knowledge the information contained herein is true, accurate, and complete.

«Insured_1»'s Signature

Dated _____

SERFF Tracking Number: LGCB-127308223 State: Arkansas
 Filing Company: Legacy Benefits, LLC State Tracking Number: 49223
 Company Tracking Number:
 TOI: VS01 Viatical Settlements Sub-TOI: VS01.000 Viatical Settlements
 Product Name: New Form Filing
 Project Name/Number: Arkansas - New Forms/

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item: Consent to Release Medical Records		
Bypass Reason: This document has previously been submitted and approved. The current filing is only with respect to revised and supplemental forms.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Escrow Agreement		
Bypass Reason: This document has previously been submitted and approved. The current filing is only with respect to revised and supplemental forms.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Physician Statement		
Bypass Reason: This document has previously been submitted and approved. The current filing is only with respect to revised and supplemental forms.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Power of Attorney		
Bypass Reason: This document has previously been submitted and approved. The current filing is only with respect to revised and supplemental forms.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: OR.10 - Offer Letter (redlined version)		

SERFF Tracking Number: *LGCB-127308223* *State:* *Arkansas*
Filing Company: *Legacy Benefits, LLC* *State Tracking Number:* *49223*
Company Tracking Number:
TOI: *VS01 Viatical Settlements* *Sub-TOI:* *VS01.000 Viatical Settlements*
Product Name: *New Form Filing*
Project Name/Number: *Arkansas - New Forms/*

Comments:

The attached shows the changes that were made to the prior, approved version of the attached document.

Attachment:

Legacy Benefits, LLC - AR.10 - Offer Letter.redlined.pdf

July 5, 2011

POLICY OWNER NAME
ADDRESS
CITY, STATE ZIP CODE

Dear POLICY OWNER:

Legacy Benefits, LLC ("LEGACY") is hereby offering to purchase your life insurance policy issued by NAME OF INSURANCE COMPANY ("INSURANCE COMPANY"), policy number POLICY NUMBER with a face amount of \$ FACE AMOUNT ("POLICY"), insuring the life of INSURED NAME, for the amount of \$PURCHASE PRICE NUMERICAL (PURCHASE PRICE – WRITTEN AMOUNT) dollars and 00/100).

In order to close the transaction, we are enclosing herewith the following documents to be completed, initialed, signed, witnessed and/or notarized by the designated party or parties as indicated below:

1. **Life Settlement Purchase Agreement and Irrevocable and Absolute Assignment of Life Insurance Policy** to be initialed on each page and signed by you and the insured (if applicable) in the presence of a notary public.
2. **Life Settlement Escrow Agreement** to be signed by you.
3. **Seller's Disbursement Instructions** to be completed and signed by you.
4. **Beneficiary's Absolute Assignment and Waiver of Claim** to be signed by each current beneficiary in the presence of a notary public.
5. **[If selling policy owner is an individual include: Consent of Policy Owner's Spouse**, if you are married, to be signed by your spouse in the presence of a notary public.]
6. **Application and Supplemental Application Forms** to be completed and signed by you, and, if applicable, the insured, and witnessed by another party.
7. **Designation of Contacts** naming one individual as the primary designee who may be contacted quarterly, as well as three alternates, to be completed and signed by the insured. The primary designee will be responsible for providing us or our designee with a certified copy of the certificate of death upon the passing of the insured.
8. **Primary Designee Acknowledgment of Responsibility** form to be

completed and signed by the primary designee as identified in the Designation of Contacts (see above item) and witnessed by another party.

9. **Life Insurance Information Release** form to be completed and signed by you and the insured and witnessed by another party.

10. **Authorization for Disclosure of Medical Information** to be completed and signed by the insured and witnessed by another party.

11. **Limited Power of Attorney Form** to be signed by the insured in the presence of a notary public.

11.~~12.~~ **Insured's Continuing Cooperation Authorization** to be signed by the insured on the first page in the presence of a notary public

12.~~13.~~ **Physician's Competency Letter** to be completed by your primary care physician. **[ONLY SEND OUT IF SELLING POLICY OWNER IS THE INSURED UNDER POLICY OR IF THE INSURED IS THE ONLY INDIVIDUAL SIGNING ON BEHALF OF OWNER.]**

13.~~14.~~ **Information Booklet & Notice of Disclosure** to be signed and dated by you.

14.~~15.~~ **Acknowledgement Form for Viatical Settlement** to be signed by you and witnessed by another party.

15.~~16.~~ **Life Settlement Commission Disclosure Statement** to be initialed and signed by you in the presence of a notary public.

16.~~17.~~ **Verification of Coverage Form** to be signed by you (on the last page).

17.~~18.~~ **Insured's Consent To Annuity Purchase form** to be completed and signed by Insured and witnessed by two additional individuals. **[ONLY IF INCLUDED IN CLOSING PACKAGE.]**

This offer and the funding of this transaction are contingent upon receipt and approval by LEGACY, to its full satisfaction, of the following documents:

(A) A currently dated LEGACY Verification of Coverage form pertaining to the POLICY, which sets forth the names of the POLICY beneficiary(ies), signed by you on the last page (see above) and completed and signed by a home office representative of the INSURANCE COMPANY;

(B) Forms of Identification:

1. If you are an individual, copies of two (2) forms of government-issued identification for each of you and the insured, plus a W-9 form that has been completed and signed by you (NOTE: the insured's IDs must include his/her date of birth, social security number, current residence and a photo of him or her and your IDs must include your social security number, current residence and a photo of you);
 2. If you are signing on behalf of a trust or other entity, copies of one form of government-issued identification for you (your ID must include a photo of you), two (2) forms of government-issued identification for the insured (NOTE: the insured's IDs must include his/her date of birth, social security number, current residence and a photo of him/her), plus a W-9 for the trust or entity that has been completed and signed by you.
- (C) All pages of a currently dated in-force illustration pertaining to the POLICY and conforming to LEGACY's requirements;
- (D) The original POLICY contract including the original application for life insurance and all amendments, riders and attachments thereto; and
- (E) Three sets of **INSURANCE COMPANY's** Change of Ownership and Change of Beneficiary forms to be signed by you and witnessed by another party (PLEASE DO NOT DATE THESE FORMS).

Also enclosed is the Buyer's Guide – Selling Your Life Insurance Policy for your review.

LEGACY has the right to withdraw this conditional offer will expire at on Deadline at 5:00 p.m. Eastern Standard Time on Expiration Date (15 days after the date of this letter) if all of the documents listed above have not been properly completed, executed and delivered to LEGACY on or before this date. Therefore, all of the documents listed above must be properly completed, executed and delivered to LEGACY before this date LEGACY further reserves the right to require additional documents or information following this date.

We expect to complete this transaction and have the funds released to you following receipt of written confirmation from **INSURANCE COMPANY** that the new owner and beneficiary has been properly recorded in its records.

If you have any additional questions, please feel free to call.

Sincerely,

LEGACY BENEFITS, LLC



Legacy Benefits, LLC
Empire State Building
350 Fifth Avenue, Suite 4320
New York, NY 10118
T 800.875.1000
T 212.643.1190
F 212.643.1180
legacybenefits.com

By: _____
NAME
TITLE

Enclosures