



***American Brokerage Services, Inc.
805 E. Willow Grove Avenue
Suite 2B
Wyndmoor PA 19038***

Ph.: 1-888-227-3131 x- 500 Fax: 215-233-9390

Please fill out the following questionnaire and return by fax to #215-233-9390



AMERICAN BROKERAGE SERVICES, INC.

Toll Free: 1-888-227-3131
Phone: 215-233-9410
Fax: 215-233-9409

803 E. Willow Grove Ave
Wyndmoor, PA 19038

LIFE INSURANCE SETTLEMENT APPLICATION

Date: ____/____/____
Insured's Name : _____ Age ____ Years _____

The information you provide on this application packet will allow American Brokerage Services, Inc. (ABS) to evaluate your request to sell your life insurance policy. Please answer the questions completely and to the best of your knowledge and ability. All of the information provided to ABS on these documents will be held in the strictest confidence. Please return the application and materials to ABS using the return envelope provided.

IMPORTANT- APPLICATION CHECKLIST [PAGE 1 OF 2]: Please include the following documents with your application, if applicable. This will allow us to process your application much more efficiently.

- PHOTOCOPY OF TWO FORMS OF ID** (i.e. Driver's License, SS Card, etc.), (Insured(s) and Policy Owner)
- PHOTOCOPY OF INSURANCE POLICY OR POLICIES**
- PHOTOCOPY OF TRUST OR CORPORATE PAPERS**
- PHOTOCOPY OF DIVORCE DECREE** (Insured and Policy Owner)
- PHOTOCOPY OF BANKRUPTCY DISCHARGE (Insured and Policy Owner)**
- PHOTOCOPY OF MEDICAL RECORDS** from all physicians you have seen within the last 3 to 4 years. This includes office notes, labs, pathology reports, etc. (Our staff will obtain these if necessary)
- NECESSARY IN-FORCE POLICY ILLUSTRATION DESIGNS**
For Universal Life Policies:
 - a. An In-force illustration showing minimum level premiums and a level death benefit, at the Current Net Interest Rate running to maturity and Zero out the Cash Value at the end of the run. Please use any cash value and dividends earned to reduce the premiums.
 - b. A 10-Year Illustration (from today's date) with level/minimum premiums, maintaining a level death benefit, using the Current Net Interest Rate, lapsing at the beginning of the 11th year after the 10-year run. Please use any cash value or dividend to pay down premiums over the life of the run.

If loans are present on the policy:

- ⇒ Please run the illustrations above showing the policy owner paying the loan total off in the first year and then maintaining a level premium and death benefit for the length of the run while zeroing out cash value at the end of each run.

For Variable Life Policies:

Policy Illustrations at 4%, 6%, and 8% Gross - three illustrations each for items a and b below:

- a. An In-force illustration showing minimum level premiums and a level death benefit, running to maturity. Zeroing out (or near zero) cash value at maturity.



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[APPLICATION CHECKLIST PAGE 2 OF 2]

- b. A 10-year illustration showing minimum level premiums and a level death benefit, running to 10 full years from today's date and lapsing immediately at the beginning of the 11th year, showing no premiums and no death benefit in the 11th year. Zeroing out (or near zero) cash value at the end of the run.

If loans are present on the policy:

- ⇒ Please run the illustrations above showing the policy owner paying the loan total off in the first year and then maintaining a level premium and death benefit for the length of the run while zeroing out cash value at maturity.

PLEASE USE THESE REQUIREMENTS AS A GUIDE FOR SUBMITTING ALL NECESSARY FORMS. IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CONTACT US TOLL FREE AT 1-888-227-3131. IF WE DO NOT RECEIVE COMPLETE INFORMATION PROVIDING THE ABOVE, THE PROCESSING OF THE APPLICATION WILL BE DELAYED.



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INSURED'S PERSONAL INFORMATION

INSURED NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
CURRENT HOME ADDRESS			
CITY	STATE	ZIP CODE	
TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
MARITAL STATUS (PLEASE CHECK ONE)			
INSURED'S DRIVERS LICENSE # & STATE	MALE / FEMALE	PLACE OF BIRTH	

INSURED'S MEDICAL INFORMATION

NAME OF PRIMARY ATTENDING PHYSICIAN	DATE LAST SEEN	TELEPHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #1		
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #2		
HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS		
PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY		
ADDITIONAL MEDICAL HISTORY		
ADDITIONAL MEDICAL HISTORY		



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Circle YES or NO where applicable

1-5 DEMOGRAPHIC

1. Name: _____

2. Address: _____

3. Sex: _____

4. DOB: _____

5a. SSN: _____

5b. Annual Family Income or Pre-Retirement Income (circle one): >\$50,000 Or <\$50,000

6. SMOKING

a. Do you currently use any kind of tobacco? Yes No

b. If yes, which type of tobacco do you use most often?

c. On average, over the last 5 years, have you smoked

i. More than 2 cigarettes/day? Yes No

ii. More than 2 cigars/day? Yes No

iii. More than 2 bowls pipe/day? Yes No

7. BUILD

a. What is your height? _____

b. What is your weight? _____



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c. How much weight have you lost or gained in the last year? _____

8. CORONARY

Have you ever:

- a. Had a heart attack? Yes No
- b. Had coronary artery bypass surgery? Yes No
- c. Had angioplasty or stenting of one or your coronary arteries? Yes No
- d. Been diagnosed with Coronary Artery Disease? Yes No
- e. Been diagnosed with left ventricular hypertrophy? Yes No
- f. Been diagnosed with congestive heart failure or cardiomyopathy? Yes No

9. CEREBRAL

Have you ever:

- a. Had a stroke? Yes No
- b. Had a Transient Ischemic Attck (TIA)? Yes No
- c. Had a carotid endarterectomy? Yes No
- d. Had carotid artery disease? Yes No
- e. Paralysis? Yes No
- f. Any other disorder/disease of the nervous system? Yes No

If so, what? _____

10. PERIPHERAL AND AORTIC



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Have you ever:

- | | | |
|--|-----|----|
| 10a. Been diagnosed with Peripheral Vascular Disease? | Yes | No |
| 10b. Had one of the arteries in your legs stented or bypassed? | Yes | No |
| 11. Have you ever been told that you have an aortic aneurysm? | Yes | No |

12. HEART VALVES

- | | | |
|--|-----|----|
| a. Have you ever had a heart valve repaired or replaced? | Yes | No |
| b. Have you been diagnosed with: | | |
| i. aortic insufficiency or regurgitation | Yes | No |
| ii. aortic stenosis | Yes | No |
| iii. mitral valve insufficiency or regurgitation | Yes | No |
| iv. mitral valve stenosis | Yes | No |

13-18. FIBRILLATION/DEFIBRILLATOR/COPD/APNEA/DIABETES/ALZHEIMERS

- | | | |
|---|-----|----|
| 13a. Have you ever been diagnosed with Atrial Fibrillation? | Yes | No |
| 13b. If yes, are you taking coumadin or other blood thinners? | Yes | No |
| 14. Do you have a cardiac pacemaker and/or defibrillator? | Yes | No |
| 15. Have you been diagnosed with Chronic Obstructive
Pulmonary Disease, Chronic Bronchitis, and/or
Emphysema? | Yes | No |
| 16a. Have you been diagnosed with Sleep Apnea? | Yes | No |



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23b. If yes, how long ago were you diagnosed? _____

23c. Were you treated? Yes No

23d. Do you currently have any evidence of Breast Cancer? Yes No

24a. Have you ever been diagnosed with Lymphoma,
Hodgkins Disease, or Leukemia? Yes No

24b. If yes, how long ago were you diagnosed? _____

24c. Were you treated? Yes No

24d. Do you currently have any evidence of Lymphoma,
Hodgkins Disease, or Leukemia? Yes No

25a. Have you ever been diagnosed with Lung Cancer? Yes No

25b. If yes, how long ago were you diagnosed? _____

25c. Were you treated? Yes No

25d. Do you currently have any evidence of Lung Cancer? Yes No

26a. Have you ever been diagnosed with cancer, other than prostate
cancer, breast cancer, lymphoma, hodgkins disase, leukemia,
or lung cancer? Yes No

26b. If so, please indicate which type of Cancer:

- Colon Yes No
- Melanoma Yes No
- Ovarian Yes No
- Esophageal Yes No



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Bone	Yes	No	
Brain	Yes	No	
Pancreatic	Yes	No	
Other	Yes	No	(_____)

26c. How long ago were you diagnosed? _____

26d. Were you treated? Yes No

26e. Do you currently have any evidence of Cancer? Yes No

27-29. HIV/HEPATITIS/RENAL

27. Are you HIV positive or have you been diagnosed with AIDS? Yes No

28. Do you have Hepatitis C or Hepatitis B? Yes No

29. Do you have renal insufficiency or other Kidney disease? Yes No

30. Any other disease or disorder not listed above? Yes No

30a. If yes, then what? _____

31. Any other operation or surgery not listed above? Yes No

31a. If yes, then what? _____

32. Are you under any other medical treatment or
observation at this time, other than what is
disclosed above? Yes No



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33. Are you currently taking any prescription medications
on a regular basis?

Yes No

33a. If yes, please indicate the name of the drug and condition for which it is prescribed.

34. Any alcohol, drug addiction, substance
abuse, mental, emotional or nervous disorders?

Yes No



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Medical History – Part II

Family History

Relationship	Age	If deceased, Cause	Age at Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Siblings	_____	_____	_____

12. Are you currently taking any prescription medications on a regular basis? If yes, please indicate the name of the drug and condition for which it is prescribed.

13. Do you currently use tobacco products? Yes _____ No _____
 Have you in the past? Yes _____ No _____ When _____

14. Any alcohol and/or drug addiction and/or substance abuse, mental, emotional, nervous disorders?
 Yes _____ No _____

15. Are you under medical treatment or observation at this time?
 Yes _____ No _____

16. Do you have plans to travel outside the U.S. in the next 2 years?
 Yes _____ No _____



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LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY	POLICY NUMBER	ISSUE DATE
<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Joint Survivorship	<input type="checkbox"/> Other
TYPE OF POLICY (PLEASE CHECK ONE)		

IF POLICY IS A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP

<input type="checkbox"/> Term	<input type="checkbox"/> Whole Life	<input type="checkbox"/> UL	<input type="checkbox"/> Group	<input type="checkbox"/> Other
CLASSIFICATION OF POLICY (PLEASE CHECK ONE)				

FACE AMOUNT	TOTAL POLICY LOAN AMOUNT	CASH SURRENDER VALUE
<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	\$ _____
POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX)		PREMIUM AMOUNT

PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ALL BENEFICIARIES OF THE POLICY (IF IT IS A TRUST, PROVIDE NAME AND ADDRESS OF TRUSTEE)

ADDITIONAL BENEFICIARIES

WHAT IS THE SPECIFIC PURPOSE FOR THE SALE OF THE POLICY OR POLICIES?

POLICY OWNER INFORMATION

NAME OF POLICY OWNER	SOCIAL SECURITY OR TAX ID NUMBER
----------------------	----------------------------------

NAME OF PRESIDENT / TRUSTEE (IF CORPORATE / TRUST OWNED POLICY)	DATE OF INCORPORATION / TRUST
---	-------------------------------

HAS POLICY OWNER EVER DECLARED BANKRUPTCY?	IF SO, HAS IT BEEN DISCHARGED?	WHEN?
--	--------------------------------	-------

ADDRESS	TELEPHONE NUMBER
---------	------------------

CITY	STATE	ZIP CODE
------	-------	----------



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FINANCIAL PROFESSIONAL INFORMATION

NAME OF REFERRING FINANCIAL PROFESSIONAL

TELEPHONE NUMBER

IF A FINANCIAL PROFESSIONAL DID NOT REFER YOU, HOW DID YOU FIND OUT ABOUT OUR COMPANY?

PERSONAL ACKNOWLEDGEMENTS

I do represent and warrant that the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify American Brokerage Services, Inc. (ABS) of any changes in the information. I further give my consent to ABS and its agents to release this application and all information gathered while processing including, but not limited to all medical records, notes, and lab reports, pertaining to my illness for the purpose of soliciting the sale of my life insurance policy. I acknowledge that I am submitting this application for you to evaluate the purchase of my life insurance policy and that you are under no obligation to purchase my policy.

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

Signature of Patient / Insured

Printed Name

Date

Signature of Policy Owner (*if not Insured*)

Printed Name

Date

NOTICE OF DISCLOSURE

1. There may be alternatives to a viatical or senior settlement contract including, but not limited to, accelerated benefits offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance policy.
2. Some or all of the proceeds of your settlement may be taxable. ABS strongly urges you to consult your own attorney or tax advisor concerning this transaction. ABS makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
4. Along with this application and its disclosures, ABS has provided an additional informational/disclosure booklet for the Policy Owner. If you have not received this booklet, please call 1-888-227-3131 to have one delivered to you, otherwise you acknowledge receipt of this booklet.

This disclosure is being made to you in compliance with the State Insurance Codes, where applicable.

[SIGNATURES APPEAR ON NEXT PAGE]



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I, the applicant, do hereby acknowledge that I have read and understand the contents of this disclosure.

Please Sign Before A Witness

Signature of Policy Owner

Printed Name

Date

Signature of Witness

Printed Name

Date



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Authorization for the Release of Information – HIPAA Compliant

I, _____ DOB _____ SS# _____ (*"Patient" or "Insured"*), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, "Authorized Discloser", hereafter referred to as, "AD"), to provide to American Brokerage Services, Inc. and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers including medical review services, LLC (collectively, "ABS"), any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV and/or AIDS, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by ABS about my coverage.

I understand that the ABS will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. ABS will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, ABS will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires ABS to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD. Any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

I specifically authorize and request my insurance company and each AD to rely upon a photographic copy or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. I have a full understanding of the Authorization's contents and I will retain a completed copy for future reference. I agree that this Authorization shall remain valid until and will expire on the date of my death or until the case is declined, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted by such law.

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Signature of Patient / Insured

Printed Name

Date: _____

Signature of Witness

Printed Name

Date: _____

Signature of Policy Owner (*if not Insured*)

Printed Name

Date: _____



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Client Name: _____ DOB: _____

Known Illness: _____

Personal Physicians – Please complete in full

Primary/Internist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Cardiologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Urologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Oncologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Neurologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Dermatologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

OB/GYN: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Gastroenterologist: _____ Phone#: _____ Fax: _____
Address: _____
Condition/Reason: _____

Medications currently taken:

_____	_____	_____
_____	_____	_____
_____	_____	_____



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Signature of Patient / Insured Printed Name Date

Signature of Policy Owner (*if not Insured*) Printed Name Date

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3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
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This disclosure is being made to you in compliance with the State Insurance Codes, where applicable.

I, the applicant, do hereby acknowledge that I have read and understand the contents of this disclosure.

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Signature of Policy Owner Printed Name Date

Signature of Witness Printed Name Date



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This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by ABS about my coverage.

I understand that the ABS will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. ABS will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, ABS will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires ABS to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD. Any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

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Signature Page

Signature of Patient / Insured

Printed Name

Date: _____

Signature of Witness

Printed Name

Date: _____

Signature of Policy Owner (*if not Insured*)

Printed Name

Date: _____

EXCLUSIVITY AGREEMENT

THIS EXCLUSIVITY AGREEMENT (this “**Agreement**”) is between the Representative who signed this Agreement (referred to as “**you,**” “**your,**” and/or “**Representative**”) and American Brokerage Services, Inc., a Pennsylvania corporation (referred to as “**ABS**”). This Agreement is effective on the date set forth next to your signature below.

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are acknowledged, and intending to be legally bound, the parties agree as follows:

1. EXCLUSIVITY. You have provided to either ABS or one of ABS’ subsidiaries or affiliates (each an “**ABS Party**” and collectively, the “**ABS Parties**”) a Single Life Settlement Request For Quotation or similar submission (“**RFQ**”) to allow such ABS Party to evaluate a request to sell the life insurance policy listed on Schedule 1 attached to this Agreement (the “**Policy**”). You understand that the ABS Parties incur certain costs and expenses including, without limitation, costs and expenses relating to internal review, physician review and actuarial review, when processing the RFQ and attempting to sell the Policy. Consequently, unless an ABS Party rejects the RFQ in writing, for a period of twelve (12) months from the date of this Agreement (collectively, the “**Restrictive Period**”) the ABS Parties shall have the exclusive right to sell the Policy. During the Restrictive Period you will not directly or indirectly, through any director, officer, employee, agent, representative, affiliate, subsidiary or otherwise: (a) solicit, initiate or encourage the submission of proposals or offers from any third party relating to the sale of the Policy; or (b) participate in any discussions or negotiations regarding, or furnish to any person any information with respect to, or otherwise cooperate with, assist, participate in, facilitate or encourage, any effort or attempt by any person to do or seek any of the foregoing.

2. DEFAULT/LIQUIDATED DAMAGES. If you breach this Agreement, you will be responsible to pay to the ABS Parties an amount equal to: (i) the costs and expenses incurred by the ABS Parties; plus (ii) ten thousand dollars (\$10,000), as liquidated damages and not as a penalty, which amount is the best estimate by the parties of the damages the ABS Parties would suffer from such breach, it being agreed that the ABS Parties’ damages are difficult if not impossible to ascertain.

3. MISCELLANEOUS PROVISIONS. This Agreement cannot be changed except in writing signed by an officer of ABS. In case one or more of the provisions of this Agreement are, for any reason, held by a court of competent jurisdiction to be invalid, illegal or unenforceable, such provision will be modified or amended to the extent necessary to remove the invalidity, illegality or unenforceability. Should the amendment or modification of such provision be impossible, the Agreement will be construed as if it never contained the invalid, illegal or unenforceable provision and such provision shall not affect any other provision of this Agreement. This Agreement will be construed and enforced in accordance with the substantive and procedural laws of the Commonwealth of Pennsylvania, excepting conflicts of laws, and without regard to rules of construction or interpretation relating to which party drafted this Agreement. The parties confer jurisdiction to interpret and enforce this Agreement upon the Courts of the Commonwealth of Pennsylvania, Montgomery County or the United States District Court for the Eastern District of Pennsylvania and waive any objections to such jurisdiction and venue, including objection as to an inconvenient forum. **THE PARTIES HEREBY WAIVE THE RIGHT TO TRIAL BY JURY, PREFERRING THAT ALL DISPUTES BE RESOLVED BY A JUDGE.** Should an ABS Party be required to enforce the terms of this Agreement in any litigation or similar proceeding, such ABS Party, if successful will be entitled to recover its attorneys’ fees, professionals’ fees and costs (which will include all appeals and execution), which will be added to any judgment. No claim or right arising out of a breach of this Agreement may be discharged in whole or in part by a waiver of the claim or right, unless the waiver is in writing signed by the waiving party. This Agreement may be executed in two or more counterparts, each of which is deemed an original, but all of which together constitute one and the same instrument. Any party to this Agreement may deliver an executed copy of this Agreement by facsimile or electronic transmission to the other party and any such delivery will have the same force and effect as any other delivery of a manually signed copy of this Agreement.

IN WITNESS WHEREOF, the parties have executed this Exclusivity Agreement under seal on the date and year set forth below.

Representative: _____

AMERICAN BROKERAGE SERVICES, INC.

By: _____(SEAL)

By: _____(SEAL)

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

SCHEDULE 1

THE POLICY

Insured: _____

Owner: _____

Ins. Co: _____

Policy #: _____