



LIFE PARTNERS INC
A LIFE SETTLEMENT PROVIDER

SENIOR LIFE ADVANTAGESM

Package Contents

FastTrac Application
Insurance and Health Releases



204 Woodhew Drive - Waco, Texas 76712
Phone: (800) 368-5569 Fax: (254) 751-1025
Email: questions@lifepartnersinc.com

*FASTRAC*SM APPLICATION

PLEASE NOTE: Receipt of a life settlement** may affect your eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SS.I), and drug assistance programs. The money you receive for your life insurance policy also may be taxable. Before completing a life settlement contract, you are urged to consult with an attorney, accountant, estate planner, financial planning advisor, your insurer or insurance agent, tax advisor, or a social service agency concerning how receipt of a payment will affect you, your family, and your spouse's eligibility for public assistance. For more information about life settlements generally, contact the Texas Department of Insurance at 1-800-252-3439.

***Life settlement* -- A transaction whereby a written agreement is solicited, negotiated, offered, entered into, delivered, or issued for delivery in this state, under which a life settlement provider acquires, through assignment, sale, or transfer of a policy insuring the life of an individual who does not have a catastrophic or life-threatening illness or condition, by paying the owner or certificate holder compensation or anything of value that is less than the net death benefit of the policy.)

ATENCION: El aceptar una liquidación tipo pago en vida** podría afectar que usted pueda inscribirse en los programas de asistencia pública, tales como los de Asistencia Médica de Medicaid, Ayuda para Familias con Hijos Menores (AFDC), Ingreso Suplementario del Seguro Social (SSI) y otros programas de ayuda para la compra de medicamentos. Es posible que también tenga que pagar impuestos por el dinero que usted reciba por su seguro de vida. Antes de firmar cualquier acuerdo tipo pago en vida lo exhortamos que consulte con un abogado, contador, planeador de patrimonios, consejero económico, su aseguradora o agente de seguros, consejero (perito) en materia de impuestos o con (y con) una agencia (las agencias) de servicios sociales para que se informe cómo el recibo de dichos pagos podría afectar su capacidad, la de su familia y la de su cónyuge para recibir asistencia pública. Para más información en general respecto a los acuerdos tipo pago en vida llame al Departamento de Seguros de Texas al 1-800-252-3439.

***Pago en Vida* - Una transacción en la cual por medio de un contrato por escrito a cumplir en este estado se solicita, negocia, ofrece, compromete, establece o expide, que bajo dicho contrato un proveedor de liquidación tipo pago en vida adquiera, por medio de asignación, venta o transferencia, la póliza de seguro de vida de un individuo que no padece de una enfermedad o padecimiento catastrófico o que amenaza la vida, al pagar al propietario o tenedor de la póliza una compensación o cualquier cosa de valor de menos cuantía que la suma neta del beneficio de muerte que estipula la póliza.



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The following questionnaire will enable Life Partners, Inc. to process your application for a life settlement. Please answer each item in this questionnaire to the best of your knowledge. Your information will be held in the strictest confidence. After you fill out the form, return to us along with a photocopy of your policy using the enclosed prepaid airbill.

PERSONAL INFORMATION

1. Your full name: _____

Current address: _____

_____ city state zip

Daytime phone (_____) _____ Evening phone (_____) _____

E-mail address: _____

2. Date of birth: _____ 3. Place of birth: _____

4. Social Security number: _____

5. Driver's License number and its state of issue: _____

6. Marital Status: single (never married) married divorced widowed

7. Father's Full Name: _____

8. Mother's Full Name
(including maiden name): _____

9. List below nearest relative or friend not living with you:

Name: _____

Address: _____

Telephone number: (_____) _____ E-mail: _____



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10. Have you ever declared bankruptcy? Yes_____ No_____

11. How did you find out about our company? _____

POLICY INFORMATION

12. What is the name of your insurance company? _____

13. What type of policy do you have? Individual Group Joint Survivor

14. Policy or Group number _____

15. What is the face amount of the policy? _____

If this is an INDIVIDUAL policy, please skip to Question #19. If this is a Group policy, please answer the questions below:

16. What is the name of the employer, association, government institution, etc., that your group policy was issued under? _____

17. What is the name, address, and contact telephone of the officer responsible for handling insurance matters in the organizations employee benefits department? _____

18. If this policy is through your employer, are you still employed? Yes_____ No_____

If no, last date of employment? _____

Are you currently on Short_____ or Long _____ term disability? Date: _____

MEDICAL INFORMATION

19. Name, address, and telephone number of your primary attending physician:



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20. Please give us the names, addresses, and telephone numbers of those attending physicians who have examined you in past 24 months and who would have relevant information regarding your illness:

21. Please provide us with a brief description of your current medical condition:

Signature of Policy Owner

Date



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**HIPAA AUTHORIZATION FOR
RELEASE OF HEALTH-RELATED INFORMATION TO
LIFE PARTNERS, INC.**

Patient: _____

SSN: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided services to me or on my behalf (“Providers”) to disclose my entire medical record and any other health or billing information concerning me (“Health Information”) to Life Partners, Inc.

Health Information includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I am authorizing the Providers to disclose health information for the purpose of determining my ongoing health status in conjunction with a life settlement transaction into which I have entered with Life Partners, Inc.

By my signature below, I acknowledge that any agreements that I have made to restrict my Health Information do not apply to limit disclosures under this authorization and I instruct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This authorization shall remain in force in perpetuity or until I execute a written revocation. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, with respect to anyone of the Providers by directly contacting the respective Provider and sending a written request for revocation directly to such Provider. I understand that a revocation is not effective to the extent that any of the Providers has already disclosed information in reliance on this Authorization. I understand that any Health Information that is disclosed pursuant to this authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release my Health Information, Life Partners, Inc. will not be able to continue to process my life settlement transaction.

I understand that I am entitled to receive a signed copy of this Authorization.

Signature of Insured or Authorized Representative

date

Description of Representative’s Authority to act for the Insured or Relationship to Insured



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**AUTHORIZATION FOR
RELEASE OF INSURANCE RECORDS**

TO: _____ **Life Insurance Co.**

RE: _____

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 Life Partners, Inc. as promptly as possible upon their request.

The purpose of this release is to facilitate a life settlement transaction into which I have entered with Life Partners, Inc.

This letter represents my continuing authorization to you, unless such consent is subsequently withdrawn, as is my legal right.

Please retain this letter in my files as a record of this authorization and release. Any correspondence with Life Partners, Inc. may be sent to the address listed above.

A signed photocopy of this release shall be equally as binding as a copy with my original signature.

Sincerely,

Signature

DATE:



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