Parcside Equity,LLC.

Application

Life Insurance Policy Information – Policy #1 **Please type or print with black or blue ink**

Insurance Company	Policy Number	Issue Date
Face Amount $	Total Policy Loan $	Net Surrender Value $
Annual Premium $	Type of Policy: Term Universal Life Variable Whole Life Second to Die	
Owner	Social Security Number	
Permanent Residence Address (owner)		
City	State	Zip
Do you have a residence in any other state? ___ No ___ Yes If so, where?	Citizenship: U.S. Other___________________	
Beneficiary		

Life Insurance Policy Information – Policy #2 (if necessary*)

Insurance Company	Policy Number	Issue Date
Face Amount $	Total Policy Loan $	Net Surrender Value $
Annual Premium $	Type of Policy: Term Universal Life Variable Whole Life Second to Die	
Owner*	Social Security Number	
Permanent Residence Address		
City	State	Zip
Do you have a residence in any other state? ___ No ___ Yes If so, where?	Citizenship: U.S. Other___________________	
Beneficiary		

* - If owner of policy #2 is different than policy #1, please copy page 4 and submit with owner's signature.

Advisor Information

Name of Attorney, CPA or other financial professional assisting you in this transaction:	Advisor's Phone Number:

Insured Information

Insured's Name		Sex: Female Male
Social Security Number	Citizenship: U.S. Other___________________	Date of Birth
Insured's Permanent Residence Address		How Long?
City	State	Zip

Insured Medical History and Condition(s) – please give a brief description

Insured Primary Physician

Name and Specialty		Date and Reason Last Seen
Address		Telephone
City	State	Zip

Insured Specialist or other Physician

Name and Specialty		Date and Reason Last Seen
Address		Telephone
City	State	Zip

Insured Hospitalization

Name of Hospital		Date and Reason for Hospitalization
Address		
City	State	Zip

If there are any other physicians that have treated you in the last three years, please attach an additional page, including full name of physician(s), specialty, address, and telephone number with area code.

SECOND INSURED (if applicable)

Second Insured's Name (if applicable)		Sex: Female Male
Social Security Number	Citizenship: U.S. Other__________________	Date of Birth
Second Insured's Permanent Residence Address		How Long?
City	State	Zip

Second Insured Medical History and Condition(s) – please give a brief description

Second Insured Primary Physician

Name Specialty		Date and Reason Last Seen
Address		Telephone
City	State	Zip

Second Insured Specialist or other Physician

Name Specialty		Date and Reason Last Seen
Address		Telephone
City	State	Zip

Second Insured Hospitalization

Name of Hospital		Date and Reason for Hospitalization
Address		
City	State	Zip

If there are any other physicians that have treated you in the last three years, please attach an additional page, including full name of physician(s), specialty, address, and telephone number with area code.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The undersigned insured(s) (hereafter referred to as “I”), authorize the disclosure of my protected health information (“PHI”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each physician, doctor, physician practice group, nurse, hospital, and any other health care provider (each, an “Authorized Discloser”) to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this authorization.

2. Person Authorized to Receive My Protected Health Information: I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to Parcside Equity, LLC. (including its officers, employees, agents, independent contractors and authorized representatives and to any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (collectively, the “Authorized Recipient”). I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web-site.

3. Description of Protected Health Information Authorized for Disclosure and the Purpose for Such Disclosure: This authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible purchase by the Authorized Recipient of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health medical status and condition in connection with any and all life insurance policies under which my life is insured that the Authorized Recipient purchases..

4. Expiration of Authorization: This authorization shall remain valid until, and shall expire on, the date of my death.

5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization 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 (a) the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained or (b), 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, my PHI disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and my PHI that is disclosed to the 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. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowingly presents false information in a life settlement application, contract or agreement is guilty of a crime and may be subject to fines and confinement in prison.

INSURED(S)

Name of Insured (please print): ______________

Signature of Insured: ______________________

Name of Second Insured (please print): _______

Signature of Second Insured:________________

Name of Witness: ___________________________

Signature of Witness: ______________________

Date: _________________________

NOTARY

State of _______ County of_______________

SS ____________________________________

Subscribed and affirmed to before me (Seal)

this _____ day of ______________,_______

Signature of Notary Public______________________

My commission expires_________________________

AUTHORIZATION TO RELEASE POLICY INFORMATION

The undersigned Owner of the policy(ies) hereby authorize the issuer of the policy(ies) to furnish Parcside Equity LLC., its reinsurers and/or its authorized representatives any information and forms (including any policy applications) they may request in connection to the policy(ies) (including any conversions thereof or replacements therefore).

The undersigned Owner agrees that a photographic copy or facsimile of this Authorization shall remain valid for the maximum period permitted by law.

The undersigned Owner hereby requests the issuer of the policy(ies) to respond promptly to this request and grants Parcside Equity LLC. a limited power of attorney to enforce this authorization on my behalf.

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Insured
Second Insured (if applicable)

PLEASE LIST ALL POLICIES:

Insurance Company	**Policy Number**

Name of Owner (please print):________________________ Signature of Owner:________________________

Date: ________________________ Witness:________________________

STATEMENT OF ACKNOWLEDGEMENT, REPRESENTATION AND WARRANTY

The following acknowledgements, representations and warranties are made by the undersigned:

To the best of the knowledge and belief of the undersigned, all statements in this application are complete, true and correctly recorded.

The undersigned represents and warrants that prior to and as a condition to the issuance of the subject life insurance policy(ies), the Insured underwent a medical examination by a physician or other medical professional during which a blood sample was taken.

The undersigned represents and warrants that they have no knowledge that the Insured or Second Insured has a terminal illness (defined as a life expectancy of twenty-four months or less) or a chronic illness (a condition which restricts a person from performing everyday functions) after consultation with their doctor(s) or healthcare workers.

The undersigned acknowledges that the **transaction will not be funded until the Application has been completed and approved.**

The undersigned acknowledges that they have received the Life Settlement Disclosure Form and the Life Settlement Seller's Guide.

_____Insured's initials   _____Second Insured's initials   _____Owner's initials

Any person who knowingly presents false information in a life settlement application, contract or agreement is guilty of a crime and may be subject to fines and confinement in prison.

Name of Insured (please print): ______________________	Signature of Insured: ______________________
Name of Second Insured (please print): ______________________	Signature of Second Insured: ______________________
Name of Owner (please print): ______________________	Signature of Owner: ______________________
Date: ______________________	Witness: ______________________

LIFE SETTLEMENT APPLICATION
DISCLOSURE STATEMENT

IMPORTANT - READ THIS DISCLOSURE STATEMENT BEFORE SIGNING THE LIFE SETTLEMENT APPLICATION.

The undersigned, as the Seller, does hereby acknowledge that the undersigned has read the Life Settlement Application Disclosure Statement (ìStatementî) with respect to the possible sale of the Seller's insurance policy number __________, issued by _____________, (ìInsurerî):

Initials of Seller

1. There are alternatives to the process of selling the Policy, which may be preferable. Some alternatives, where applicable, are (1) borrowing against the cash value of the Policy, or (2) surrender of the Policy, or (3) an ìAccelerated or Living Benefit Option.î Information on these alternatives should be obtained directly from the Insurer that issued the Policy or your financial or insurance advisors. ________________

2. Receipt of the sale proceeds may adversely affect the Seller's eligibility for Medicaid, supplemental Social Security Income or other governmental benefits or entitlements. Advice should be obtained from the appropriate agency or from a professional advisor. ________________

3. The sale proceeds may be subject to claims by creditors, personal representatives, trustees in bankruptcy and receivers in state and federal courts. ________________

4. Some or all of the proceeds of the settlement may be taxable under federal income tax and state franchise and income taxes, and assistance should be sought from a professional tax advisor. ________________

5. Funds will be sent to the Seller within three (3) business days after Parcside has received the Insurer or group administratorís acknowledgment that ownership of the Policy or interest in the certificate has been transferred and the beneficiary has been designated. ________________

6. Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the Policy or certificate, to be forfeited by the Seller. Assistance should be sought from a financial advisor. ________________

7. All medical, financial or personal information solicited or obtained by Parcside or a viatical settlement broker about an insured, including the insuredís identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the viatical settlement between the Seller and Buyer. If you are asked this information, you will be asked to consent to the disclosure. This information may be provided to someone who buys the Policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years. ________________

8. The insured may be contacted by either Parcside Equity LLC. or its authorized representative for the purpose of determining the insuredís health status. ________________

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SELLER

Signature of Seller___________________________

Print Name of Seller__________________________

NOTARY

State of __________ County of _________________

SS: ___________________________________

Subscribed and affirmed to before me
(Seal)
this ___ day of ________________,___________

Signature of Notary Public ______________________

My commission expires: ________________________

BUYER

AGREED and ACCEPTED this ____ day of _____________,_______.

By (Signature for Buyer) __________________________

Type Name____________________________

Title__________________________________