Veris Settlement Partners
291 Main Street
Northport, NY 11768
Phone: 631-239-6655
Fax: 631-239-6657
www.go2veris.com

Small Face Amount Simplified Form

*Please **answer all questions** for policies from $100,000 to $500,000.*

Insured Information

1. Name of Insured ______________________ Sex_______ SS#______________________
2. Address ____
3. Phone Number ____
4. Date of Birth ____

Policyowner Information

5. Name of Policyowner ____
6. Address ____

Policy Information

7. Insurance Company ____
8. Face Amount of Policy ____
9. Policy Number ____
10. Type of Policy (only Universal Life, Convertible Term and Survivor Universal Life with one insured deceased)
____
11. Current Premium ____
12. Payment mode (such as Annual, Semiannual, Quarterly, Monthly) ______________________
13. Cash Surrender Value ____
14. Policy Issue Date (mm/dd/yyyy) ____
15. Underwriting Class (only Standard or Preferred accepted) ______________________

Authorization to Obtain Life Expectancy Report

I, ______________________, (name of insured) authorize LSL and its agents to contact me to conduct an interview in order to provide a Life Expectancy Report which will be used in connection with valuating my Life Insurance policy #__________________ (policy number) issued by ______________________ (insurance company) for the purposes of a Life Settlement transaction.

Signature of insured ____

Phone Number: ______________________ Best time to call: ______________________

Referrring Advisor ______________________ Phone Number ______________________

Signature ______________________ Date ______________________

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Authorization for Disclosure of Protected Health Information (HIPAA Compliant)

For Life Settlement

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

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each authorized HCP to rely upon photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each authorized HCP to disclose my PHI under this authorization to Veris Settlement Partners, Inc., American Viatical Services, Inc., Fasano Associates, Inc., Examination Management Services, Inc., 21st Services, including any of their affiliates, agents, subsidiaries, corporate parents, independent contractors, authorized representatives, service providers, life settlement providers and the officers, directors, and employees of each (each an "Authorized Recipient"). I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to an authorized recipient, including transmission via web posting to a secure website.

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, records, whether or not personally or individually 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 purpose of allowing authorized recipients (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, certificate of life insurance, under which my life is insured to the authorized recipient and (2) to monitor, track, and verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacement therefore, that Veris Settlement Partners, Inc. brokers.

4. Expiration: This authorization shall remain valid until one (1) year after 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 HCP by notifying such authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such authorized HCP; provided, that any revocation of this authorization shall not apply to the extent that the authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

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6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provisions of Authorization: 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 if 1996 (the "HIPAA Privacy regulations"). I further understand that, as a result of this authorization, there is potential for my PHI that is disclosed by an authorized HCP to an authorized recipient to be subject to redisclosure by an 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 executing and delivering this authorization freely and unilaterally 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 a copy of this signed authorization for future reference.

Signature of Insured 1

Printed Name of Insured 1 Date

Signature of Insured 2

Printed Name of Insured 2 Date

Signature of Witness

Printed Name of Witness Date