Insured Personal Information

Name of Insured: _____

Date of Birth: _____ Gender: _____

Are you a U.S. Citizen or Resident?: Yes: ___ No: ___ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (day): _____ Phone(eve): _____

Best Time to Call: _____ Best Phone No.(For EMSI Interview): _____

Life Insurance Policy Information

Name of Insurance Company (as shown on the policy): _____

Policy Number: _____ Coverage/Face Amount _____

Issue Date: _____ Rate Class: _____

Beneficiary(ies): _____

_____

_____

Are premiums paid and up to date? Yes: ____ No: ____

Has policy ever been reinstated? Yes: ____ No: ____ If so, when? _____

Reason for selling Policy: _____

_____

POLICY OWNER INFORMATION

Check one:

____ Individual (Please complete Section A)

____ Trust (Please complete Section B)

____ Corporation, Partnership, LLC, or Other Legal Entity (Please complete Section C)

Is the Owner the original owner of this policy? Yes: ____ No: ____

If No, explain how, when, and from whom the policy was acquired: _____

_____

Section A: If Policy Owner is an Individual

(If more than one individual owns the policy, please complete this section for each individual owner)

Name of Policy Owner: _____

Social Security#: _____ Relationship to Insured: _____

Address:_____ City: _____ State: _____Zip: _____

Phone: _____ Email: _____

Are you a U.S. Citizen or Resident?: Yes: ____ No: ____ State of Primary Residence: _____

Marital Status: _____

Current Spouse Name and Address: _____

Have you ever been divorced? Yes: ____ No: ____ Date(s): _____
(If Yes, we will require a copy of the Divorce Decree(s) before contracts are issued)

Have you ever declared bankruptcy? Yes: ____ No: ____ Date(s):_____
(If Yes and bankruptcy after policy issued date, we will require a copy of the Bankruptcy Discharge before contracts are issued)

Is there any agreement or court order requiring you to maintain the policy for the benefit of any child, spouse, former spouse, domestic partner, or any other person? Yes: ____ No: ____

Does any other person or party have or claim any rights or interest in the policy? Yes: ____ No: ____

If yes, explain: _____

Section B: If Policy Owner is a Trust

(A copy of the trust will be required before closing documents are issued)

Full Name of the Trust: _____

Type of Trust: _____ Tax ID #: _____

Date of Formation: _____ State of Formation: _____

Name of Trustee: _____

Trustee's Address: _____ City: _____ State: _____ Zip: _____

Trustee's Phone: _____ Trustee's Email: _____

Names of Trust Beneficiaries: _____

_____

Section C: If Policy Owner is a Legal Entity

(A copy of the articles of incorporation and corporate bylaws will be required before closing documents are issued)

Name of Legal Entity: _____

Type of Entity: _____ State of Formation: _____ Tax ID #: _____

Name of Primary Contact: _____

Contact Title: _____

Contact's Address: _____ City: _____ State: _____ Zip: _____

Contact's Phone: _____ Contact's Email: _____

INSURED'S MEDICAL INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your file. Please, complete all questions.

PART I: INDIVIDUAL INFORMATION

Primary Caregiver: _____

Address:_____ City: _____ State:_____ Zip:_____

Phone: _____Fax:_____

Date of Last Physical Exam: _____ Height: _____Weight: _____

PART II: FAMILY HISTORY

FATHER Age: ____ OR Age at death: _____ Significant Health Problems:_____

If deceased, was death from CAD or Cancer prior to age 65: Yes ____ No ____

MOTHER Age: ____ OR Age at death: _____ Significant Health Problems:_____

If deceased, was death from CAD or Cancer prior to age 65: Yes ____ No ____

SIBLING Male: ____ Female: ____ Age: ____ Significant Health Problems:_____

SIBLING Male: ____ Female: ____ Age: ____ Significant Health Problems:_____

SIBLING Male: ____ Female: ____ Age: ____ Significant Health Problems:_____

PART III: HEALTH

Check if you have, or have had, any symptoms in the following areas to a significant degree.

Alcoholism	Alzheimer's Disease/Dementia	Aortic Aneurysm	Anemia
Atrial Fibrillation/Arrhythmia	Cancer	Cardiomyopathy	Carotid Artery disease
Cerebrovascular disease	Cirrhosis/Liver disease	Congestive Heart Failure	COPD/Asthma/Respiratory
Coronary Artery disease	Diabetes	Major Depression	Emphysema
Heart Murmur	Hyperlipidemia	Hypertension	Kidney Problems
Memory Loss	Pacemaker	Parkinson's disease	Peripheral Vascular disease
Rheumatoid Arthritis	Sleep Apnea	Stroke	TIA
HIV	AIDS	Other	

Briefly explain any items checked above. Please, include the date of diagnosis and treatment as well as the physician or health professional's name.

_____

PART IV: MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Name of Drug:_____ Strength: _____Frequency Taken: _____ Prescribed for: _____

Name of Drug:_____ Strength: _____Frequency Taken: _____ Prescribed for: _____

Name of Drug:_____ Strength: _____Frequency Taken: _____ Prescribed for: _____

Name of Drug:_____ Strength: _____Frequency Taken: _____ Prescribed for: _____

Name of Drug:_____ Strength: _____Frequency Taken: _____ Prescribed for: _____

Allergies to Medications:
Name of Drug:_____ Reaction You Had: _____

Name of Drug:_____ Reaction You Had: _____

PART V: SURGICAL HISTORY

Please list any surgeries or procedures you have had within the past 5 years.

Year: _____ Reason: _____Hospital: _____

Year: _____ Reason: _____Hospital: _____

Year: _____ Reason: _____Hospital: _____

Other hospitalizations within the past 5 years
Year: _____ Reason: _____Hospital: _____

Year: _____ Reason: _____Hospital: _____

PART VI: PHYSICIAN INFORMATION

List name and contact information for all other physicians or health professionals you see:

Name: _____ **Address:**_____ **Phone:**_____

Name: _____ **Address:**_____ **Phone:**_____

Name: _____ **Address:**_____ **Phone:**_____

PART VII: Limitations

Please check any limitations with or hardships performing the following and explain:

___ Bathing	Self-Feeding	Handle Finances	Ability to do heavy work around the house
Toileting	___Continence	Do Housekeeping	Transferring (example, from bed to chair)
Shop	___Prepare Food	___Use Transportation	___Participate in outside social activities
Dressing	Use a Telephone	Walk half a mile	Participate in more strenuous exercise
			Take medication properly

PART VIII: OTHER

TOBACCO

Do you use tobacco? No: ____ Yes: ____ Number of Years: ____ or Year Quit: _____

Cigarettes: ____ Chew: ____ Pipe: ____ Cigars: ____ Number per day: ____

ALCOHOL

Do you drink alcohol? No: ____ Yes: ____ What kind? _____

Number of drinks per week: ____

Have you ever received a DUI / DWI? No: Yes: Number: ____ Date of last offense: _____

DIET

Have you unintentionally lost more than 15 pounds in the past 12 months? Yes: ____ No: ____

Are you on a physician prescribed medical diet? Yes: ____ No: ____

EXERCISE

_____ Sedentary (no exercise)

Mild exercise (i.e., climb stairs, walk three blocks, golf)

Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 minutes)

___ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

HEALTH STATUS

Excellent Good Poor Fair

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY LIFE SETTLEMENT PROVIDER OR OTHER PERSON FILES AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT LIFE SETTLEMENT ACT, WHICH IS A CRIME.

YOU MAY ALSO BE SUBJECT TO A CIVIL PENALTY.

In signing this Inquiry, each of the undersigned Policy Owner(s) and Insured(s) hereby acknowledges, represents and warrants the information provided in this Inquiry is true and correct to the best of his/her knowledge.

POLICY OWNER

_____	_____	_____
Signature	Printed Name	Date

INSURED

_____	_____	_____
Signature	Printed Name	Date

INSURED

_____	_____	_____
Signature	Printed Name	Date

Windsor
Life Settlements LLC

INSURED'S HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION (PRIMARY INSURED)

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 photocopy 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 (including its officers, employees, agents, independent contractors and authorized representatives] (including but not limited to financing entities and life expectancy evaluation companies)] 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 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 (and/or its funding entities) 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 for twelve months after the date it is signed, or for the maximum extent allowed by law from the date thereof.

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.

INSURED: _____ **Signed Date:** _____

Printed Name: _____

Date of Birth: _____

Address: _____

City, State Zip: _____

Social Security #: _____

WITNESS: _____ (Disinterested, unrelated party)

WINDSOR LIFE SETTLEMENTS LLC
33 N. LaSalle Street, Suite 2400
Chicago, IL 60602

TOLL FREE: 888-994-6376
PHONE: 312-335-6000
FAX: 312-291-8960
www.Windsorls.COM

AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

Life Insurance Company _____ **Policy Number** _____

Printed Name of All Policy Owner(s) _____ **Printed Name of Insured(s)** _____

I hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy to release such information to and reply immediately to any written, telephonic or other request for information or documents required by WINDSOR LIFE SETTLEMENTS LLC and/or its authorized representatives pertaining to the above-referenced life insurance policy that I own.

I authorize WINDSOR LIFE SETTLEMENTS LLC to share this information with life settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for life settlements, and/or life and health insurance policies.

Authorized by:

Signature of **Primary Insured** _____ Printed Name _____ Date _____

Signature of **Secondary Insured** (if applicable) _____ Printed Name _____ Date _____

Signature of **Policy Owner #1** (if not Insured) _____ Printed Name _____ Date _____

Signature of **Policy Owner #2** (if not Insured) _____ Printed Name _____ Date _____