

POLICY INFORMATION SHEET
About the Policy (the "Policy")

Carrier:	Policy Number:
Base Face Amount:	Policy Issue Date:
Insuring (check one): <input type="checkbox"/> Individual <input type="checkbox"/> Joint-Survivor	Rate Class at Issue:
Policy Type (check one): <input type="checkbox"/> UL <input type="checkbox"/> GUL <input type="checkbox"/> IUL <input type="checkbox"/> VUL <input type="checkbox"/> Term Convertible <input type="checkbox"/> Term Non-Convertible <input type="checkbox"/> Whole Life <input type="checkbox"/> Group	
Guaranteed Term Period (if Term):	Term Conversion Expiration Date (if Term):
Current Account Value:	Current Cash Surrender Value:
Outstanding Loan Balance:	Date Last Premium Paid:
Amount of Last Premium Paid:	Mode (check one): <input type="checkbox"/> Annual <input type="checkbox"/> Semi An. <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly

Has the Policy been submitted to another life settlement company?

Insured Name(s)

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Beneficiary Name(s) & Beneficiary Amount/Percentage

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Owner Detail (1)

Full Name:	
Ownership %:	E-mail:
SSN / TIN:	DOB:
Address:	
Landline Phone:	Cell Phone:
Power of Attorney In Effect?: <input type="checkbox"/> YES or <input type="checkbox"/> NO	Bankruptcy filed? <input type="checkbox"/> YES IN YEAR(S) _____ or <input type="checkbox"/> NO
Marital Status:	Ever been divorced? <input type="checkbox"/> YES IN YEAR _____ or <input type="checkbox"/> NO

Owner Detail (2)

Full Name:	
Ownership %	E-mail:
SSN / TIN:	DOB:
Address:	
Landline Phone:	Cell Phone:
Power of Attorney In Effect?: <input type="checkbox"/> YES or <input type="checkbox"/> NO	Bankruptcy filed? <input type="checkbox"/> YES IN YEAR(S) _____ or <input type="checkbox"/> NO
Marital Status:	Ever been divorced? <input type="checkbox"/> YES IN YEAR _____ or <input type="checkbox"/> NO

INSURED INFORMATION SHEET

About the Insured

First Name:	Last Name:	
Landline Phone:	Cell Phone:	
E-mail:	Occupation:	
DOB:	SSN:	
Street Address:		
City:	State:	Zip:
Total Amount of Life Insurance Inforce:		
Power of Attorney In Effect?: <input type="checkbox"/> YES or <input type="checkbox"/> NO	Bankruptcy filed? <input type="checkbox"/> YES IN YEAR(S) _____ or <input type="checkbox"/> NO	
Marital Status:	Ever been divorced? <input type="checkbox"/> YES IN YEAR _____ or <input type="checkbox"/> NO	

Insured Underwriting Participation

If requested by LifeRoc, is the Insured willing to complete a ParaMed Exam?	<input type="checkbox"/> YES or <input type="checkbox"/> NO
If requested by LifeRoc, is the Insured willing to grant access to their Medical Records Online Portal?	<input type="checkbox"/> YES or <input type="checkbox"/> NO
If requested by LifeRoc, is the Insured willing to complete a Health Phone Interview?	<input type="checkbox"/> YES or <input type="checkbox"/> NO

Insured Health Profile

Do You Still Drive?: <input type="checkbox"/> YES or <input type="checkbox"/> NO	Have you had any fall(s) in past 5 years? <input type="checkbox"/> YES or <input type="checkbox"/> NO
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Tobacco Use in the past 5 years (If none, write "None" to indicate that)

Check Product Type (below)	Date Last Used	Amount / Frequency
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Other		

List Current Medications (If none, write "None" to indicate that)

Medication Name	Reason Taking	Length / Frequency / Dosage

List Major Surgeries or Illnesses in the past 10 years & Other Notes (If none, then write "None" to indicate that)

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**Has the Insured ever been treated for or diagnosed with any of the following?
 Answer with "Yes" or "No" as applicable; provide details in the "Additional Comments" section below.**

Alcohol/Drug Abuse <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Anemia/Blood Disorder <input type="checkbox"/>
Brain Disorder <input type="checkbox"/>	Breathing Problems <input type="checkbox"/>	Broken Bones <input type="checkbox"/>
Cancer <input type="checkbox"/>	Chronic Pain <input type="checkbox"/>	Dementia/ Alzheimer's <input type="checkbox"/>
Depression/Anxiety <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Dizziness/Vertigo <input type="checkbox"/>
Heart Attack <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>
High Cholesterol <input type="checkbox"/>	Immune Disorder <input type="checkbox"/>	Kidney Issues <input type="checkbox"/>
Liver Issues <input type="checkbox"/>	Neurological Issues <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>
Pancreas Issues <input type="checkbox"/>	Sleep Apnea <input type="checkbox"/>	Stomach/Digestive/Colon <input type="checkbox"/>
Stroke/TIA <input type="checkbox"/>	Tumors/Cysts <input type="checkbox"/>	Thyroid Issues <input type="checkbox"/>

Insured Doctor & Hospital Information (Past 5-10 years)

Primary Physician

Name:	Specialty:
Date Last Seen:	Reason:
Telephone:	City & State:

Specialist / Facility

Name:	Specialty:
Date Last Seen:	Reason:
Telephone:	City / State:

Specialist / Facility

Name:	Specialty:
Date Last Seen:	Reason:
Telephone:	City & State:

Specialist / Facility

Name:	Specialty:
Date Last Seen:	Reason:
Telephone:	City & State:

Specialist / Facility

Name:	Specialty:
Date Last Seen:	Reason:
Telephone:	City & State:

AUTHORIZATION FOR RELEASE OF POLICY INFORMATION

By executing this Authorization for Release of Policy Information (this "Authorization"), the undersigned person ("Signatory"), an owner of one or more life insurance policies or duly acting on behalf of such owner ("Policyowner", who may or may not also be Signatory), hereby authorizes the insurance carrier identified below, and its respective affiliates, assigns, and designees (collectively, "Insurer"), to release to LifeRoc Capital, LLC and its respective officers, directors, employees, agents, representatives, affiliates, assigns, and designees (collectively, "Company"), by voice, phone, facsimile, e-mail, mail, and/or other commercially-reasonable means of transmission (as the context reasonably supports), any and all information and/or documentation which Company requests in connection with Policyowner and/or the Policy, without limitation, including but not limited to financial and credit-related information of Policyowner, a true, correct & complete copy of the life insurance policy described below (the "Policy"), certificates evidencing the issuance and in-force status of the Policy, annual statements, in-force Illustrations, verifications of coverage, account values, Policy information, Insurer forms, rider or amendment details, and other Policy-specific or related information, for any and all legal purposes. Signatory may revoke this Authorization in writing if such revocation is delivered to Company via first-class certified postage-prepaid mail, return receipt requested. Any otherwise-valid revocation of this Authorization by Signatory is not effective to the extent Company and/or Insurer acts in good faith reliance on this Authorization.

Policy Information:

Insurer/Carrier:	Policy Number:
Owner Name:	Owner TIN or SSN:

Persons Authorized to Act on Behalf of the Company:

Alyssa Durr (Sr. Case Manager); Morgan Cummings (Case Manager); Geoff Palya (Sr. Vice President); Daniel Weaver (Analyst); Travis Gallina (Director of Operations); Cierra Secrest (Analyst), Chelsea Christensen (Case Manager), Aaron Giroux (Manager), Nick Williams (VP), Joseph McCray (Sr. Vice President), Brandon Marz (CSO & Manager), Marisa Gray (Case Manager), and all other LifeRoc Capital, LLC employees, persons, designees and representatives.

Authorization & Signature

This Authorization may be signed in any number of counterparts, if and as needed, which together shall constitute one and the same Authorization, and a photocopy or facsimile of this signed Authorization shall be treated, and may be relied upon, as an original. **By signing this Authorization, Signatory acknowledges and agrees this Authorization is written in plain English, Signatory has read and fully understands this Authorization, and Signatory will retain a copy of this Authorization, once duly completed and signed by Signatory, for his, her, or its records, respectively.**



SIGNATURE OF OWNER

X: _____

Owner Name: _____

Signor Name: _____

Signor Title: _____

Date: _____

INSURED AUTHORIZATION TO RELEASE HEALTH INFORMATION (HIPAA Authorization)

By executing this Insured Authorization Form (this "Form"), the undersigned (the "Insured") under one or more life insurance policies (the "Insured") authorizes the disclosure of my protected health information ("PHI") as defined under the regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 as follows:

1. I authorize each doctor, hospital, nurse, pharmacy, pharmacy benefit manager, physician, physician practice group, and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below.

2. I authorize each Authorized HCP to disclose my PHI under this authorization to LifeRoc Capital, LLC and its respective affiliates, subsidiaries, independent contractors, agents, representatives, service providers; and any of their respective successors, assigns and transferees of any life insurance policy insuring my life and any life insurance producer, and if the policy was issued less than two years from the date of application for a life settlement contract, to the insurance company that issued the policy covering my life (each, an "Authorized Recipient"). I understand that my PHI may be obtained by a third-party provider and may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website.

3. This authorization shall apply to any and all of my health and medical data information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. regulations, including, without limitation: (1) any life expectancy analysis relating to me; (2) drug or alcohol abuse; (3) mental health conditions, including, but not limited to, treatment in a psychiatric hospital; (4) a sexually transmitted disease; (5) a communicable disease required to be reported to a state health agency; (6) infection with human immunodeficiency virus(HIV), test results for exposure to HIV infection, or diagnosis of having ARC (AIDS-related complex) or AIDS caused by HIV infection or another sickness or condition caused by or derived from such HIV infection, or other HIV-related information; (7) mental retardation; (8) a genetic disease, genetic information, or results from genetic tests; (9) a condition that resulted in residence and/or treatment in a sanatorium, rest home, nursing home, boarding home, or related institution; or (10) a condition for which treatment was provided by an ambulance service.

4. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (I) 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 under which my life is insured to any Authorized Recipient and (2) to monitor, track or verify my health, life or medical status and condition in connection with any life insurance policy under which my life is insured that LifeRoc Capital, LLC purchases.

5. This authorization shall remain valid until, and shall expire on, two (2) years from the date of my signature below, or such other date, if any, as may be required by applicable law or regulation.

6. If at any time the undersigned desires to rescind the authorization set forth in this Form, the undersigned may do so in a signed writing indicating that intent, delivered to: LifeRoc Capital, LLC, 19000 MacArthur Boulevard, Suite 450, Irvine, CA 92612, Fax: 310-819-9512; 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.

7. No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

8. I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA and its regulations.

I certify that I am executing and delivering this authorization freely. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.



SIGNATURE OF INSURED

X: _____

Insured Name: _____

Insured DOB: _____

Insured SSN: _____

Signor Name: _____

Signor Title: _____

Date: _____