CAPITAL TRUSTS, INC.
4200 Wisconsin Avenue NW
Washington, DC 20016-2143
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Phone: (202) 237-5700
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Vince@CapitalTrustsInc.com

Life Insurance Settlement Application

Please print out and complete

Personal Information: (Please Print)

Full Legal Name: ____

Social Security Number: ________ – ______ – ________ Date of Birth: ____ /_____ /_____

Address: ____

City: __________________________________ State: __________ Zip: ________________

Residence Telephone: ___________________ Cell Phone:___________________________

Driver's License Number: ______________________________ State of Issue: ____________

(Please enclose a photocopy of the license)

Marital Status:

❒ Single ❒ Married ❒ Separated ❒ Widowed ❒ Divorced

If Married, Name of Spouse: ____

Spouse Social Security: ________ – ______ – ________ Date of Birth: ____ /_____ /_____

Have you ever been or are you currently a party to a bankruptcy proceeding, civil lawsuit,

judgment, tax lien or a creditor lien? ❒ Yes ❒ No

If yes, please explain: ____

____

____

Life Insurance Policy Information

(Please include a copy of the policy. If you have more than One Policy please duplicate this page.

Policy Owner (if not the insured): ____

Social Security Number: _______ – ______ – ________ Date of Birth: ____ /_____ /_____

Address: ____

City: ________________________________ State: __________ Zip: ________________

Residence Telephone: __________________ Cell Phone:___________________________

Is this the Original Owner?: ❒ Yes ❒ No

If No, Please list Previous Owner(s): ____

Insurance Company Name: _________________________ Policy #______________________

Amount of Coverage $___________________ Amount of Premium $___________________

Payment Frequency: ❒ Annual ❒ Semi-annual ❒ Quarterly ❒ Monthly

Date of issue: ______/______/______

List the Beneficiaries of this Policy and their Relationship to you:

1.____ Relationship: ___________________

2.____ Relationship: ___________________

3.____ Relationship: ___________________

Medical Information

Please list the name, address and telephone number of your Primary Physician.

Physician Name: ____

Address: ____

City: __________________________________ State: __________ Zip: _______________

Telephone: ____________________________ Fax: _________________________________

If you belong to an HMO, your medical record number: ________________________________

Please list the names and addresses of all doctors you have seen within the last 24 months.

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Terms and Conditions

I, the applicant and owner of said policy, do swear that all the information contained in this application to Capital Trusts, Inc. is true and correct to the best of my knowledge, and that I am in fact that person identified in the attached photocopy of my drivers license or photo identification. That I further understand that Capital Trusts, Inc. is under no obligation to purchase my life insurance policy. That I further agree to the release of any and all information and documents pertaining to this transaction, as requested from me or any third party, including a credit report by a Credit Reporting Agency, to the officers, administrators and agents of Capital Trusts, Inc. for the purpose of verifying such information.

Applicant Signature: ____

Applicant Printed Name: _____________________________ Date: ______/______/ 20______

State of : ______________________

County of : ______________________

Subscribed, sworn to and acknowledged before me this _____day of ________, 20______

____________________________________ My Commission Expires: ______/______/______

Notary Public

In lieu of a notary signature, two witnesses are acceptable:

Witness Name: _______________________ Signature: ______________________________

Witness Name: _______________________ Signature: ______________________________

Authorization To Release Medical Information

In order to effectuate a life insurance settlement, I hereby authorize any physicians, medical personnel, clinics, hospital, medical centers, medical bureaus and related institutions, to release to Capital Trusts, Inc. of Washington, DC or its designees and its authorized personnel, any medical information regarding my health or physical condition. This is to include all information which may be of a sensitive and confidential nature.

I agree that this authorization is valid for the maximum statutorily authorized period from the date signed, and that a photocopy of it is a valid representation of the original.

_________________________________ _________________________________

Signature Printed Name

State of : _______________________

County of : _______________________

Subscribed, sworn to and acknowledged before me this _____day of ________, 20______

____

Notary Public

My Commission Expires: ______/______/______

Authorization To Release Policy Information

TO WHOM IT MAY CONCERN:

I have contracted with Capital Trusts, Inc. of Washington, DC to review my insurance coverage. They are acting as agents on my behalf to learn about and verify my insurance coverage with your company. As such, please treat any and all inquires and requests made by Capital Trusts, Inc., and its agents as if they are made by me directly. I hereby authorize you to send Capital Trusts, Inc. and/or its designees any information you would normally restrict to sending me, the Insured.

I hereby authorize Insurance Company: ____

The issuer of life insurance policy number: ______________________________________

Owned by: ____

Insuring the life of : ____

to release to Capital Trusts, Inc., or its authorized representatives, any information concerning the above mentioned policy.

____________________________________ ________________________________

Signature Printed Name

State of : _______________________

County of : _______________________

Subscribed, sworn to and acknowledged before me this _____day of ________, 20______

___________________________________ My Commission Expires: ______/______/______

Notary Public

HIPAA – Compliant PHI Release Form

Authorization for Disclosure of Protected Health Information

I, ___________________________________ authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to disclose my protected health information as specified below:

Name(s) ____________________________________ Organization(s) _____________________________

Address: ____________________________________ City: ______________________ State: _____ Zip: _______

I authorize the following person(s) and / or organization(s) to receive my protected health information, as disclosed by the person(s) and / or organization(s) above.

Name(s) ____________________________________ Organization(s) _____________________________

Address: ____________________________________ City: ______________________ State: _____ Zip: _______

Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

1. Specific description of the purpose for each use or disclosure (or write “at the request of the individual” in this space):
2. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and / or organization(s) named above have taken action in reliance on this authorization.

This authorization expires on ___________/_________/20________, or in the event that (event) ____, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction

Signed: ____ Date: _________________________

Name: ____ SS #: _______-______-_________

Address: ____ Telephone: __________________

Relationship or Authority of Personal Representative (if applicable): ____

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[1] Protected Health Information (“PHI”) is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment of the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.F. 164.508

[2]These laws apply to health plans, health care providers, and health care clearinghouses.