

Capital Trusts, Inc.

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Life Insurance Settlement Application

Personal Information: (Please Print)

Full Legal Name:

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Address:

City: _____ State: _____ Zip: _____

Residence Telephone: _____

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 Date of Birth: _____ / _____ / 19____

Social Security Number: _____ - _____ - _____

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)

Policy Owner (if not the insured): _____

Address:

City: _____ State: _____ Zip: _____

Telephone Number(s):

Social Security Number: _____ - _____ - _____

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 mode: () 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: _____

(If you have more than One Policy please duplicate this page).

Medical Information

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

(If you belong to an HMO, please provide your medical record number.)

Name: _____

Address: _____

Phone number: _____

City: _____ State: _____ Zip: _____

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

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. Inc. for the purpose of verifying such information.

Signature of the Applicant: _____

Date: ____/____/20____

State of : _____ County of : _____

Subscribed, sworn to and acknowledged before me this ____ day of _____, 20____

by: _____

Applicant's signature and printed name.

Notary Public My Commission Expires: ____/____/____

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

Witness

Witness

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

by:

Insured

Notary Public

My Commission Expires: _____/_____/20_____

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:

the issuer of the life insurance policy number:

owned by:

and insuring the life of :

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

Signature: _____

Printed Name:

Subscribed, sworn to and acknowledged before me this ____ day of _____, 20____,

by: _____ Insured

Notary Public

Commission Expires: _____ / _____ / 20 _____

HIPAA – Compliant PHI Release Form

Authorization for Disclosure of Protected Health Information

I, _____ authorize the disclosure of my protected health information¹ 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 laws², 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 _____

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 _____

A. 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 _____, or in the event that
(date) _____, whichever occurs first.
(event)

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: _____

Address: _____

Telephone: _____

SS #: _____

Relationship or Authority of Personal Representative (if applicable)

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.