



Insurance Strategies Group, LLC
 8853 Commodity Circle Suite 5
 Orlando, Florida 32819
 800-978-4131 Fax: 407-455-5561
 www.ISGhome.com

Life Insurance Valuation Form – Not an Application

This Life Insurance Valuation Form is an informal inquiry and is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an insurance settlement application and in no way guarantees specific underwriting or binds any offers.

Personal Information

First Insured Name: _____ Male Female SS #: _____

Current Address: _____

Date of Birth: _____ Age: _____ Telephone Number: _____

Marital Status: Single Married Divorced Widowed

Dependent Children: Yes No - If yes, list names: _____

Second Insured Name: _____ Male Female SS #: _____

Current Address: _____

Date of Birth: _____ Age: _____ Telephone Number: _____

Marital Status: Single Married Divorced Widowed

Dependent Children: Yes No - If yes, list names: _____

Have you been or are you now a party to bankruptcy? Yes No - If yes, please attach all discharge documents.

If policy owner is different than above

Policy Owner/s (Trust Name): _____

Name of Trustee (i/a): _____ SS# or Tax ID#: _____

Owner Address (State if Trust): _____

Date of Trust: _____ Daytime Telephone: _____ Evening Telephone: _____

Life Insurance Policy Information

Name of Insurance Company (1): _____ Policy Number (1): _____

Date Policy was issued: _____ Coverage/Face Amount: \$ _____

Annual Premium: \$ _____ Date Last Premium Paid: _____ Date Next Premium Due: _____

Current Surrender Amount: \$ _____ Current Cash Value: \$ _____ Loan Amount: \$ _____

Type of Policy: Universal Life Survivor Universal Life Term Whole Life Survivor Whole Life Variable Life Group

Reason for Valuation: New Insurance / Reduce or Eliminate Premiums Policy No Longer Needed Create Income Stream w/ Immediate Annuity

Other: _____

Name of Insurance Company (2): _____ Policy Number (2): _____

Date Policy was issued: _____ Coverage/Face Amount: \$ _____

Annual Premium: \$ _____ Date Last Premium Paid: _____ Date Next Premium Due: _____

Current Surrender Amount: \$ _____ Current Cash Value: \$ _____ Loan Amount: \$ _____

Type of Policy: Universal Life Survivor Universal Life Term Whole Life Survivor Whole Life Variable Life Group

Reason for Valuation: New Insurance / Reduce or Eliminate Premiums Policy No Longer Needed Create Income Stream w/ Immediate Annuity

Other: _____



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Medical History *Please complete one per insured*

Insured's Primary Care Physician: _____

Address: _____

Telephone: _____ Facsimile: _____

Insured's Specialist (1): _____

*Type of Specialty: _____

Address: _____

Telephone: _____ Facsimile: _____

Insured's Specialist (2): _____

*Type of Specialty: _____

Address: _____

Telephone: _____ Facsimile: _____

Insured's Specialist (3): _____

*Type of Specialty: _____

Address: _____

Telephone: _____ Facsimile: _____

Have you had any of the following?

- Heart Attack Date(s)
Stroke Date(s)
Cancer Type? Date(s)
Kidney Disease Date(s)
Liver Disease Date(s)
Other Date(s)

Tobacco use? Yes No

*Describe any medical problems: _____

*List any medications you are currently taking: _____



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NOTICE OF DISCLOSURE

Seller may have certain tax consequences resulting from the sale of a life insurance policy and should request assistance from a professional tax advisor. The sale of a life insurance policy may affect your right to receive government benefits or entitlements. There may be possible alternatives to selling your life insurance; this may include the option of an Accelerated Death Benefit offered by your insurance company. You are advised to consult a financial advisor, certified public accountant or an attorney regarding these potential alternatives. Settlement proceeds could be subject to the claims of creditors. Seller acknowledges that Insurance Strategies Group, LLC is not responsible for any failure on the part of a potential buyer to purchase seller's policy(s) on terms offered by a potential buyer through Insurance Strategies Group, LLC. Seller acknowledges that Insurance Strategies Group, LLC is not responsible for the accuracy of any representations made by a potential buyer of seller's policy(s) (even if such representations are communicated to seller by Insurance Strategies Group, LLC), and seller will look solely to the potential buyer of seller's policy(s) in the event that Seller believes that a potential buyer has made misrepresentations to Seller or otherwise failed to perform on purchase offers or other representations. As Owner/Seller, you acknowledge that you are authorizing Insurance Strategies Group, LLC to negotiate on your behalf with, but not limited to all, Life Settlement providers, intermediaries, brokers, servicers, and underwriters, of which you may have applied, to secure the maximum legitimate reputable offer for your policy(s). The amount and method used by Provider/Purchasing Company to compensate Insurance Strategies Group, LLC/Brokers/ Producers service fee is up to ten percent of the policy(s) coverage amount. Insurance Strategies Group, LLC will be compensated from provider if the policy is sold. All or part of this fee may be paid to Insurance Strategies Group, LLC and/or its designees by purchaser if the policy is sold. Seller acknowledges that it's Producers, Agents, Brokers, Advisors, Attorneys, CPA's may all communicate to secure the maximum legitimate reputable offer for your policy(s) and may share in disclosed service fee. Seller acknowledges that Insurance Strategies Group, LLC is not a buyer of life insurance policies and incurs substantial expense in underwriting and brokering your policy(s) therefore, has earned and is due any compensation sent to us by purchasing company, if policy(s) are sold. Seller acknowledges that Insurance Strategies Group, LLC may allow seller or seller's Advisor to complete the transaction directly with the preferred funding source and/or sellers and Advisor's preferred intermediary. I hereby appoint Insurance Strategies Group, LLC exclusive Irrevocable Broker of Record for the purpose of negotiating the sale of my Life Insurance policy(s).

TERMS AND CONDITIONS

Any person who knowingly and with intent to injure, defraud, or deceive any insurance related entity, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison. The signer warrants and represents that all information contained in this document is true and correct to the best of his/her knowledge.

Signature of Policy Owner

Date

Print Name

Signature of Witness

Date

Print Name



HIPPA COMPLIANT
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ONE PER INSURED

I, the undersigned individual, 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, laboratory 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.

2. Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose my PHI under this authorization to (a) Insurance Strategies Group, LLC, its affiliates and any of their directors, officers, employees, agents, independent contractors, service providers or other representatives and (b) any viatical or life settlement company or broker with which Insurance Strategies Group, LLC may transact business (each, an "Authorized Recipient").

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 and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (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, or certificate of life insurance, under which my life is insured to any Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any Authorized Recipient purchases.

4. Expiration of Authorization. This authorization shall remain valid until, and shall expire on, the date of my death. [Note- if this form is designed to inure to the benefit of the VSPs with whom you work, then we may want to extend the duration to a fixed period after death, such as 6 months after death to allow the VSPs to get PHI in connection with a death claim.]

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.

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition your treatment, payment, enrollment or eligibility for benefits on whether you 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 of 1996 (the "HIPAA Privacy Regulations"). 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 Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below 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 and retained a copy of this signed authorization for future reference.

Signature of Insured

Signature of Personal Representative of Individual

Print Name of Insured

Description of Personal Representative's Authority
(Power of Attorney, Guardian at Litem or similar status)

Date
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Date
ISG Rev 7/06



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Authorization for Release of Life Insurance Policy Information

PLEASE COMPLETE ONE PER POLICY

Policy Information:

(Complete all requested information)

Policy Number:

Name of Insurance Company:

Insured's Name:

If Individually Owned:

Owner's Name:

Owner's Social Security #:

Owner's Address:

City, State, Zip Code:

If Trust Owned:

Trust Name:

Trustee Name:

Trust Tax ID#: Trust Date:

Trust State/Address:

Authorization and Signatures

I/We hereby authorize the insurance company to release any and/or all information or forms to Insurance Strategies Group, LLC, its employees, life settlement brokers/funders, and/or its authorized representatives on the above referenced policy. I/We understand that the information authorized for release may include, but is not limited to, insurance policy information, illustrations, in-force ledgers, verification of coverage, premium schedules, forms, riders, financial information, and amendments from the insurance company, group policy holder, employer, benefit plan administrator, or any other institution. I/We agree that a photographic copy of this authorization shall be valid as the original. I/We agree that this authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absence any provision of any applicable state statute or regulation to the contrary, and which event it shall remain valid for the maximum period permitted hereunder. I/We acknowledge and understand that I may revoke this Authorization at any time by notifying Insurance Strategies Group, LLC of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at the address designated by Insurance Strategies Group, LLC.

If Individually Owned: Owner's Signature Date

Owner's Name

2nd Owner's Signature (If applicable) Date

2nd Owner's Name

If Trust Owned: Trustee's Signature Date

Trustee's Name