



Qualification Form

PERSONAL INFORMATION

First Insured Name: _____ SS # _____

Current Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Second Insured Name: _____ SS # _____

Current Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Daytime Telephone Number: _____ Evening Telephone Number: _____

Marital Status: _____ Male: _____ Female: _____ Dependent Children: Yes () No ()

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

IF POLICY OWNER IS DIFFERENT THAN INSURED

Policy Owner (if other than insured): _____

Name of Trustee: _____ SS or Tax ID #: _____

Current Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Daytime Telephone Number: _____ Evening Telephone Number: _____

Marital Status: _____ Male: _____ Female: _____ Dependent Children: Yes () No ()

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

Please list any additional Owners, Trustees or Beneficiaries including address and telephone information on a separate sheet.

Signature of Insured: _____ Date: _____

Signature of Policy Owner(s)/Viator _____ Date: _____

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LIFE INSURANCE POLICY INFORMATION

Name of Insurance Company: _____

Policy Number: _____ Date policy was issued: _____

Coverage/Face Amount:\$ _____ Amount of Premium:\$ _____
(monthly/quarterly/semi-annually/annually)

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

Type of Policy: Term () Whole Life () Universal Life () Group (employer) () Other ()

Policy Premium Financed? - Yes () No () Finance Company _____

What is the Reason for the Sale of this Policy? _____

MEDICAL HISTORY

Name of Personal Physician(s): _____

Address: _____

City/State/Zip: _____

Telephone #: _____ Facsimile #: _____

Give a description of your current and past medical condition(s) and diagnosis dates:

Please list the names and phone numbers of any additional Physicians and/or Specialists:

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

FRAUD WARNING

ANY PERSON WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE OR AN APPLICATION FOR A LIFE SETTLEMENT CONTRACT IS GUILTY OF CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signature of Insured: _____ Date: _____

Signature of Policy Owner(s)/Viator _____ Date: _____

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VIATICAL SETTLEMENT APPLICATION AND DISCLOSURE STATEMENT

1. There are alternatives to the process of selling your policy which may be preferable. Some alternatives, where applicable, are borrowing against the policy, surrendering the policy, or an accelerated death benefit option. Information on these alternatives should be obtained from the Insurer that issued the policy.
2. Receipt of the proceeds of a Viatical Settlement may adversely affect the viator's eligibility for Medicaid, supplemental Social Security Income or other governmental benefits or entitlements. Advice should be obtained from the appropriate government agencies.
3. Proceeds of a Viatical Settlement may be taxable, or subject to the claims of creditors. Before completing a Viatical Settlement contract, you are urged to consult with a personal tax advisor. The money you receive for your life insurance policy could be taken away from you by creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
4. The viator has the right to know, upon request, the identity of any person who will receive or has received a commission or other form of compensation from the Viatical settlement provider with respect to their Viatical settlement and the amount and terms of such compensation.
5. Trinity Financial Services, LLC, will be compensated. The Viatical settlement provider company, not the viator, will compensate Trinity Financial Services, LLC, based on a formula that is a percentage of the face value of the life insurance policy. For example: compensation for a \$500,000 policy could be: $8\% \times \$500,000$ (face value) = \$40,000.00. Compensation can include, but is not limited to, bonuses, overrides or other funds in addition to agent commissions.
6. The viator has the right to rescind a Viatical Settlement contract up to fifteen (15) calendar days after the receipt of the Viatical Settlement proceeds by the viator, depending on State regulations. If the insured dies within the rescission period, the Viatical Settlement contract shall be deemed to have been rescinded, subject to repayment of all Viatical Settlement proceeds.
7. Funds will be sent to the viator within three (3) business days after the Escrow Agent has received the insurer acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated. The name, address and telephone number of the Escrow Agent is located within the contracts from the Viatical Settlement Provider. **NOTE:** You may inspect or receive copies of the relevant escrow agreement.
8. All medical, financial or personal information solicited or obtained by a Viatical settlement provider or a Viatical settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the Viatical settlement between the viator and the Viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.
9. **Notice to Applicant.** Trinity Financial Services makes no representation or guaranty that Applicant's policy(s) will be sold. Trinity Financial Services is not responsible for any failure on the part of a potential Viatical settlement provider to purchase Applicant's policy(ies) on terms offered by a Viatical settlement provider through Trinity Financial Services. Trinity Financial Services is not responsible for the accuracy of any representations made by a Viatical settlement provider of Applicant's policy(ies). Applicant acknowledges that he/she has determined the relative benefit or any such Viatical settlement transaction after review of the legal and financial implications of such a settlement with his/her attorney, accountant, or other appropriate advisor. Applicant has voluntarily released his/her medical records requested by Trinity Financial Services and acknowledges that he/she freely and voluntarily provided the information requested as part of the Qualification Form.

Signature of Insured: _____ Date: _____

Signature of Policy Owner(s)/Viator _____ Date: _____

Signature of Witness: _____ Date: _____

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**AUTHORIZATION FOR DISCLOSURE OF INSURANCE POLICY INFORMATION AND PROTECTED
HEALTH INFORMATION
(HIPAA COMPLIANT)**

The undersigned insured (hereafter referred to as “I”, “me” or “my”), 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. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, an “Authorized Discloser”) to provide **Trinity Financial Services, LLC** and/or its authorized representative, my life insurer (collectively, the “Authorized Recipient”) with any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, drug or alcohol abuse, of or related to the insured.
2. This authorization allows for the disclosure, inspection, and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatments or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors’ notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. This authorization shall apply to any and all of the insured’s health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.
3. Release of Policy Information. (For Financial Purposes). I understand that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, Verification of Coverage, Illustrations, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my life insurance company to furnish Trinity Financial Services, LLC with any information herein described above.
4. I understand that Viatical settlement providers, their medical underwriters, contingency re-insurers and any other entity which requires or is compelled by law to receive such PHI to complete a viatical settlement contract transaction or in order to sell a viatical settlement contract (each “Authorized Recipient”) will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy(ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. 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. I agree that a photocopy or facsimile of this authorization shall be valid as the original.
5. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under.

1st Insured or Patient’s Signature: _____ Date: _____

2nd Insured or Patient’s Signature: _____ Date: _____

Policy Owner’s/Viator Signature: _____ Date: _____

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AUTHORIZATION CONTINUED

- 6. 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 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 Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
- 7. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization: I understand that this authorization is voluntary and I am not required to sign. No Authorized Discloser or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I 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 HIPPA 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 Discloser to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPPA 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.

Any person who knowingly presents false information in an application for insurance or an application for a life settlement contract may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of 1st Insured: _____ Date: _____

Signature of 2nd Insured: _____ Date: _____

Signature of Policy Owner/Viator : _____ Date: _____

Signature of Witness: _____ Date: _____

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