

WELCOME TO ASHAR

We are experts in the secondary market for life insurance policies specializing in handling the many complex details that are part of the settlement process. Our goal is to assist clients wishing to exercise their rights as life insurance policy owners and insureds to investigate the possibility of receiving more for their policies than may be offered through traditional policy surrenders.

Our success is built on trusted relationships with many of the nation's top planning advisors. We earn our reputation every day by leveraging our strong relationships with the premiere institutional funding sources such as banks and other capital markets groups to benefit our clients.

You can be certain we respect your privacy and that the personal information you provide us will be handled confidentially. We will constantly be focused on your interests throughout the administrative process. Our definition of success is an outcome that pleases you.

When we receive your *Inquiry* forms, we will begin work on what could be a lengthy process. Timely return of these completed forms and necessary documents help us work efficiently. Our energetic, experienced staff of industry experts will then navigate the process expeditiously for you.

Again, welcome. It's a privilege for us to help achieve your goals. We're looking forward to success!

Sincerely,

Jon B. Mendelsohn
President and CEO

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

In order to assist processing your *Inquiry* packet, please provide the following:

• Referring Advisor Name:		• Email:	
• Address:			
• City:	• State:	• Zip Code:	• Phone:
• Please Contact:		• <i>If support staff:</i>	
<input type="checkbox"/> Me <input type="checkbox"/> Support Staff		• Email:	• Phone:



We are **i.i.f.e.** - Life Insurance Feasibility ExpertsSM

407.772.1818 • 800.384.8080

www.ashargroup.com

Dear Policy Owner, Insured and Referring Advisor (if applicable):

Ashar Group, LLC and its authorized employees, contractors, representatives and agents (“Ashar”) is an independent financial advisory firm that focuses on providing market valuations and brokering the sale of existing life insurance policies to purchasers in the secondary market. Ashar has no financial or other affiliations with the parties with whom Ashar works with while acting as the Policy Owner’s and Insured’s representative. Ashar’s only compensation for its services, which includes but is not limited to policy assessment, obtaining and forwarding life expectancy reports, best execution negotiations, medical underwriting, insurance verifications and final contract preparation, is determined in accordance with the provisions set forth in Paragraph Seven (7) below. Ashar does not collect any “hidden fees.” Unlike other competitive firms, Ashar does not raise capital or report to outside investors. Ashar’s goal is to obtain contingent offers that maximize the Policy Owner’s return on the existing policy and to represent his or her best interests throughout the relationship.

The purpose of this Acknowledgement, Authorization & Agency of Record is to a) disclose to each undersigned certain policies and procedures followed by Ashar when brokering the sale of the existing life insurance policy or policies owned by the Policy Owner issued by **(insert Insurer Name)** _____ with policy number or numbers **(insert Policy Number(s))** _____ (the “Policy” regardless if more than one) in the secondary market for life insurance; b) secure the acknowledgements and representations of each applicable undersigned of the information contained herein; and c) authorize Ashar to work on behalf of each undersigned. Please be advised that the matters discussed below are not intended to be exhaustive of all policies and procedures adhered to by Ashar.

Each undersigned is identified below (please complete even if Policy Owner and Insured are the same):

PRINTED NAME OF POLICY OWNER	PRINTED NAME OF POLICY OWNER #2 (if applicable)
PRINTED NAME OF PRIMARY INSURED	PRINTED NAME OF SECONDARY INSURED (if applicable)
PRINTED NAME OF REFERRING ADVISOR #1 (if applicable)	PRINTED NAME OF REFERRING ADVISOR #2 (if applicable)

The Acknowledgements and Authorizations of each applicable undersigned are as follows:

1. **No Policy Owner Obligation:** The Policy Owner is under no obligation to accept any contingent offers secured by Ashar.
2. **Acquiring Contingent Offers:** After obtaining all appropriate and requisite releases, Ashar will complete an internal medical review and pricing analysis of the Policy. Ashar adheres to strict procedures in the receipt and acceptance of contingent offers. The Policy Owner acknowledges that Ashar shall, and the Policy Owner specifically authorizes Ashar to, communicate to prospective purchasers of the Policy an “end date” – this is the date after which offers by prospective purchasers will not be accepted. Without an “end date,” the process would include a great deal of uncertainty for all parties involved. Ashar shall consult with the Referring Advisor, if applicable, regarding the determination of an “end date” and Ashar shall advise potential purchasers of the Policy of the “end date” determined. The Policy Owner authorizes the Referring Advisor, if applicable and on his, her or its behalf, to a) determine the “end date;” b) accept and decline any and all contingent offers secured by Ashar; c) to communicate to Ashar acceptance of any contingent offer in order for Ashar to proceed with the sale of the Policy; and d) represent his, her or its interests regarding the potential sale of the Policy. The Referring Advisor, if applicable, in turn, accepts the above authorization. Please be advised that Ashar is relying upon the above authorizations by the Policy Owner and each undersigned acknowledges such reliance. If there is no Referring Advisor, then the Policy Owner authorizes Ashar, at the direction of the Policy Owner, to a) determine the “end date;” b) accept and decline any and all contingent offers; c) to accept any contingent offer in order to proceed with the sale of the Policy; and d) represent his, her or its interests regarding the potential sale of the Policy
3. **Confidentiality:** Ashar adheres to strict internal policies and procedures to protect confidential data involving the Policy Owner and the Insured. All confidential data furnished to Ashar is only shared with third parties outside of Ashar on a need-to-know basis in furtherance of a) establishing the market value of the Policy; and b) the potential sale of the Policy.

4. **Additional Authorizations:** The Policy Owner and Insured authorize Ashar to a) release and/or transmit electronically all collected financial and insurance information to the appropriate parties, as determined by Ashar in good faith, who have an identifiable need to facilitate the potential sale of the Policy; b) act as exclusive representative to facilitate the sale of the Policy beginning on the date of the Policy Owner’s signature and continuing for a period of one hundred eighty (60) days after the final offer is obtained/acquired for the Policy; and c) operate pursuant to its customary and typical business practices in relation to the potential sale of the Policy, including but not limited to identifying the type and amount of prospective purchasers and the “end date” described in Paragraph Two (2) above.

5. **Additional Acknowledgements:** Each undersigned acknowledges the following: a) that the commitment to Ashar, for the period of time described in Paragraph Four (4) above, excludes facilitating the sale of the Policy with any other entity or individual, including but not limited to other financial professionals other than the Referring Advisor, if applicable, pursuant to this Acknowledgement & Authorization; b) that this Acknowledgement, Authorization & Agency of Record nullifies any and all previous authorizations designating any party, other than Ashar and the Referring Advisor, if applicable, as representative to facilitate the sale of the Policy; c) if the Policy Owner does not accept a specific contingent offer, then all work product created in connection with producing such contingent offer shall remain the exclusive property of Ashar; d) Ashar issues no guarantee that the Policy will be sold; e) Ashar is under no obligation to ultimately locate a purchaser of the Policy or to purchase the Policy itself; f) Ashar is not responsible for any breach committed by a potential purchaser of the Policy or any representative of the potential purchaser of the Policy; and g) Ashar, in order to facilitate the potential sale of the Policy, requires documentation including but not limited to current in-force illustrations for the Policy, as specified by Ashar; copy of two forms of identification for the Policy Owner and Insured; copy of the Policy and the application for the Policy; copy of any trust or corporate formation documents indicating ownership of the Policy, if applicable; copy of any divorce decree of the Policy Owner and/or Insured, if applicable; copy of any bankruptcy discharge of the Policy Owner and/or Insured, if applicable; and copy of all premium finance contracts, if applicable.

6. **No Intent to Sell Policy:** The Policy Owner hereby represents and warrants to Ashar that the Policy Owner did not procure the Policy with the intent to sell the Policy.

7. **Fee Disclosure:** The gross fee payable to Ashar and the Referring Advisor, if applicable, for the services associated with the sale of the Policy shall collectively not exceed eight percent (8%) of the Net Death Benefit of the Policy, even if in some states fees must be directly correlated to the purchase price of the Policy. Based upon Ashar’s experience, the above fee calculation is reasonable in the secondary market for the sale of existing life insurance policies and each undersigned acknowledges that such fee calculation is reasonable. Please note if Ashar is successful in facilitating the sale of the Policy, the Policy Owner is paid and any and all applicable rescission periods have expired, the Policy Owner may be required to pay Ashar, at Ashar’s discretion, all necessary transactional costs required by third party service providers associated with the sale of the Policy, including but not limited to fees for acquiring life expectancy reports, Policy illustrations and medical records. Please be advised that Ashar shall never require reimbursement if such reimbursement shall cause Ashar’s gross fee to be more than the percentage described above. In the event that Ashar is unable to successfully facilitate the sale of the Policy and the Policy Owner is not paid, there are no fees whatsoever due and owed to Ashar of any kind, unless agreed upon in writing per a separate agreement.

8. **Funding of Premiums:** Except as noted below, the premiums have been funded by the Insured and/or immediate family members of the Insured.

9. **Power of Attorney:** Except as noted below, the Policy Owner and Insured have not signed a Power of Attorney (“POA”) granting a legal representative to act on his or her behalf related to or associated with the potential sale of the Policy.

If the Insured (Primary or Secondary) has a POA, then please identify below:

If the Policy Owner (or any Policy Owner) has a POA, then please identify below:

10. **Referring Advisor Representations (If Applicable):** The Referring Advisor, if applicable, represents that he or she: a) is the primary and often only direct contact with the Policy Owner to determine suitability and the value and merit of selling the Policy; b) has determined that selling the Policy is suitable for the Policy Owner; c) is acting in a fiduciary capacity and always in the best interest of the Policy Owner during the potential and/or actual sale of the Policy; d) shall determine the best use of any proceeds from the sale of the Policy; and e) understands that Ashar is relying upon the above Referring Advisor representations, if applicable, to move forward with the potential sale of the Policy.

By signing below, each undersigned understands the authorizations, acknowledgements and representations above and has had the opportunity to ask any questions or express any concerns regarding this Acknowledgement, Authorization & Agency of Record.

PRINTED NAME	SIGNATURE OF POLICY OWNER	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF POLICY OWNER #2 (if applicable)	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF PRIMARY INSURED	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF SECONDARY INSURED (if applicable)	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF REFERRING ADVISOR (if applicable)	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF REFERRING ADVISOR #2 (if applicable)	DATE
	<small>Please Sign & Date</small>	
PRINTED NAME	SIGNATURE OF AUTHORIZED REPRESENTATIVE OF ASHAR	DATE
	<small>Please Sign & Date</small>	

Pre-Submission Checklist: (PLEASE COMPLETE CHECKBOXES BELOW)

- Inquiry completed
- HIPAA/Medical Release completed *
- Insurance Release completed *
- Current Illustrations: Depending on type of policy (see requirements listed below)
 - Please check one: Advisor will provide Ashar should obtain with Insurance Release Provided
- Current Account and Surrender Value
- Medical Records – The longer of the last 5 years or 2 years prior to the policy issue date from both Primary Physician and Specialist
 - Please check one: Advisor will provide Ashar should obtain with HIPAA/Medical Authorization Provided
- Copy of Policy including application
- Photo ID of Owner and Insured (Driver's License, State ID Card, or Passport)
- Copy of all Premium Finance Documents, if applicable
- Copy of Trust or Corporate Documents, if applicable
- Referring Advisors Only; all applicable licenses and self-appointments as required by state regulation
 - *Insurance companies and medical facilities may require additional specific forms

Illustration Requirements:

1. Run at current assumptions
2. Show all loans paid in full in the current policy year

Additional Requirements per policy type:

Universal Life:

1. Run with minimum level premium required to maintain level death benefit to age 100 with \$1 - \$1000 at maturity.
2. Run using the minimum guaranteed premium if the policy has a guaranteed no-lapse premium or secondary guarantee.
3. If the policy has an Increasing Death Benefit or Return of Premium Death Benefit, run **a)** with the current death benefit option showing minimum premium to carry the policy to maturity and **b)** assuming the death benefit option is changed to level and then showing a level premium required to maintain level death benefit to age 100 with \$1 - \$1000 at maturity.

Whole Life:

1. Run showing premium offset in earliest possible year.
2. Run showing dividends applied to reduce premiums.
3. If policy has a term rider, the illustrations must show the full death benefit maintained to age 100.

Term Life:

1. Term Premium Schedule
2. If policy is still within the conversion period, a conversion illustration assuming the policy will be converted to the best available conversion product, preferably a Universal Life.

NOTE: In order to obtain the best possible offers for your clients, we may request additional illustrations.

Contracts/Closing Items Checklist:

- Original or Certified copy of insurance policy (A Certificate of Insurance is not acceptable to most funders)
- Most recent annual statement
- Completed W-9
- Copy of insured's social security card
- Final verification of policy values by insurance carrier
- Letter of Competency may be required
- Divorce Decree of Policy Owner, if applicable
- Bankruptcy Discharge of Policy Owner, if applicable
- Spousal Consent if policy is individually owned. Also may be required under other circumstances.
- Policies issued within past 3 years
 - Premium payment history
 - Proof of premium payments
- Previously recorded Change of Ownership or Beneficiary Form if this has changed since policy issuance

PERSONAL DATA:

• Insured's Name:		• Date of Birth:	• Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
• Social Security #:	• US Citizen?: <input type="checkbox"/> Yes <input type="checkbox"/> No	• Height:	• Weight:
• 2nd Insured's Name:		• Date of Birth:	• Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
• Social Security #:	• US Citizen?: <input type="checkbox"/> Yes <input type="checkbox"/> No	• Height:	• Weight:
• Insured's Address:			
• City:	• State:	• Zip:	

• Does Insured(s) own residence in another state(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	• If yes, provide address and months per year spent at each residence:
• Is Client Applying For New Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	• Anticipated Date New Insurance Inforce:

INSURED MEDICAL INFORMATION (*Attach separate page if necessary*):

• Insured Medical History and Conditions:		
• Primary Physician:	• Date and Reason Last Seen:	
• Address:	• Telephone:	
• City:	• State:	• Zip:
• Insured's Specialist:	• Specialty:	
• Date and Reason Last Seen:		
• Address:	• Telephone:	
• City:	• State:	• Zip:
• Hospitalizations:	• Date and Reason Last Seen:	
• Address:	• Telephone:	
• City:	• State:	• Zip:

2ND INSURED MEDICAL INFORMATION (*Attach separate page if necessary*):

• 2 ND Insured Medical History and Conditions:		
• Primary Physician:	• Date and Reason Last Seen:	
• Address:	• Telephone:	
• City:	• State:	• Zip:
• 2 ND Insured's Specialist:	• Specialty:	
• Date and Reason Last Seen:		
• Address:	• Telephone:	
• City:	• State:	• Zip:
• Hospitalizations:	• Date and Reason Last Seen:	
• Address:	• Telephone:	
• City:	• State:	• Zip:

LIFE INSURANCE POLICY INFORMATION – PLEASE COMPLETE SEPARATE FORM FOR EACH POLICY:

• Insurance Company:		• Policy #:		• Issue Date:	
• Face Amount: \$		• Total Policy Loan: \$		• Current Annual Premium: \$	
• Total Premiums Paid \$:		• Next Premium Due:		• Current Cash Surrender Value: \$	
• Maturity Age:	• Policy Type: <input type="checkbox"/> Universal Life <input type="checkbox"/> Term <input type="checkbox"/> Survivorship <input type="checkbox"/> Whole Life <input type="checkbox"/> Variable Life				
• If survivorship policy, are both insured's living? <input type="checkbox"/> Yes <input type="checkbox"/> No		• If no, name of deceased insured?			
• Does the Policy have a Double Indemnity provision? <input type="checkbox"/> Yes <input type="checkbox"/> No					
• Does the policy have a Maturity Extension Rider? <input type="checkbox"/> Yes <input type="checkbox"/> No		• If yes, to what age?			
• Is this policy assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No			• If yes, who is the assignee?		
• Has the policy or any of the policy premiums been financed by a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No		• If yes, please answer the following: What Program?			
• Estimated loan payoff?			• Maturity date of loan?		
• Policy Owner:			• Owner's Social Security # or Tax ID:		
• Relationship to Insured:		• Policy Owner's Permanent Address:			
• City:		• State:		• Zip:	
• Policy Owner's Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
• Has the Policy Owner ever declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No			• If yes, has it been discharged? <input type="checkbox"/> Yes <input type="checkbox"/> No		
• Date Discharged?		• Is the Policy Owner currently involved in a legal proceeding? <input type="checkbox"/> Yes <input type="checkbox"/> No			
• If policy is trust owned, full legal name of trust:					
• Situs of Trust:			• Policy Beneficiary:		
• List <u>all</u> Trustees with Address and Phone Numbers:					




PLEASE LIST OTHER INFORCE LIFE INSURANCE POLICIES ON INSURED:

• Insurance Company:	• Face Amount: \$
• Insurance Company:	• Face Amount: \$
• Insurance Company:	• Face Amount: \$

PLEASE LIST OTHER INFORCE LIFE INSURANCE POLICIES ON 2ND INSURED:

• Insurance Company:	• Face Amount: \$
• Insurance Company:	• Face Amount: \$
• Insurance Company:	• Face Amount: \$

Fraud Warning: Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and, upon conviction, may be subject to fines or confinement in prison, or both.

_____ NAME OF PRIMARY INSURED	 _____ SIGNATURE OF PRIMARY INSURED	_____ DATE
_____ NAME OF SECONDARY INSURED	 _____ SIGNATURE OF SECONDARY INSURED	_____ DATE
_____ NAME OF POLICY OWNER	 _____ SIGNATURE OF POLICY OWNER	_____ DATE

Suitability Verification for the Sale of Existing Life Insurance

Please be advised that Ashar Group, LLC will not be able to exhaustively assist Policy Owner(s) and/or Insured(s) in determining the merits of selling their existing life insurance policy or policies based on their specific needs and situations without the disclosure of the financial related and personal information as requested below.

Please check here if Policy Owner(s) chooses not to complete the information below and declines the assistance of the Ashar Group, LLC in determining suitability.

Policy Owner's Net Worth
(Please check one)

- \$0 - \$49,999
- \$50,000 - \$99,999
- \$100,000 - \$199,999
- \$200,000 - \$499,999
- \$500,000 - \$999,999
- \$1,000,000 - \$2,499,999
- \$2,500,000 - \$4,999,999
- \$5,000,000 +

Reason For Considering Sale
(Check ALL that apply)

- Planning to surrender or allow policy to lapse
- No longer want or need coverage
- Premiums have become too costly
- Alternative to a 1035 exchange
- Seeking replacement policy
- Estate planning needs have been met
- Need cash liquidity for health & living expenses
- Interested in determining market value of policy
- Other (please describe):

Verified and Confirmed By:

<hr/>	Please Sign & Date	<hr/>
PRINTED NAME	SIGNATURE OF POLICY OWNER	DATE
<hr/>	Please Sign & Date	<hr/>
PRINTED NAME	SIGNATURE OF POLICY OWNER #2 (if applicable)	DATE
<hr/>	Please Sign & Date	<hr/>
PRINTED NAME	SIGNATURE OF PRIMARY INSURED (if different than above)	DATE
<hr/>	Please Sign & Date	<hr/>
PRINTED NAME	SIGNATURE OF SECONDARY INSURED (if different than above)	DATE
<hr/>	Please Sign & Date	<hr/>
PRINTED NAME	SIGNATURE OF REFERRING ADVISOR (if applicable)	DATE

Fraud Warning: Any person who knowingly presents false information in an application for insurance or a viatical/life settlement contract is guilty of a crime & may be subject to fines & confinement in prison.

1. **Ashar Group, LLC** and your referring advisor, if any, represents only you and shall act according to your instructions and in your best interest notwithstanding the manner in which **Ashar Group, LLC** and your referring advisor, if any, is compensated.
2. Some or all of the proceeds of your viatical/life settlement may be taxable under federal income tax and/or state franchise and income tax laws. **Ashar Group, LLC** is not a tax advisor and recommends that you consult your own professional tax advisor regarding this transaction.
3. The sale of your insurance policy may affect your right to receive Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Viatical/life settlement proceeds could be subject to the claims of creditors.
5. There may be possible alternatives to selling your life insurance. This may include the option of an accelerated death benefit or policy loans offered by your life insurance company. You are advised to consult a financial advisor, certified public accountant and/or an attorney regarding these potential alternatives.
6. You have the right to rescind a viatical/life settlement contract before the earlier of thirty (30) calendar days after the date upon which the viatical/life settlement contract is executed by all parties or fifteen (15) calendar days after your receipt of the proceeds. Rescission, if exercised, is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans and loan interest to the viatical/life settlement provider is made within the rescission period. If the insured dies during the rescission period, then the viatical/life settlement contract is deemed to have been rescinded if repayment of all proceeds and any premiums, loans and loan interest to the viatical/life settlement provider is made within forty-five (45) days after the end of the rescission period.
7. Funds will be sent to you within three (3) business days after the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated. **Ashar Group, LLC** and your referring advisor, if any, has no access to or control over viatical/life settlement provider funds that are set aside in escrow or trust.
8. Entering into a viatical/life settlement contract may 1) cause other rights or benefits, including conversion rights and waiver of premium benefits, which may exist under the policy or a certificate of a group life insurance policy to be forfeited; and 2) reduce the insured's ability to obtain additional life insurance coverage in the future.
9. Total compensation payable to **Ashar Group, LLC** and your referring advisor, if any, shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds of your settlement are represented by the Net Purchase Price (NPP) as follows: $NPP = \text{Gross Purchase Price (GPP)} - \text{total compensation}$ as paid by the viatical/life settlement provider reduced by the total compensation as described above.
10. All medical, financial or personal information solicited or obtained by a viatical/life settlement provider or a life insurance producer about the 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/life settlement between you and the viatical/life settlement provider. If

you are asked to provide this information, you will be asked to consent to this 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 (2) years. In addition, information regarding the policy owner's and insured's identity and insured's medical condition will 1) be shared with the insurer that issued the life insurance policy; and 2) shall be available to each subsequent owner of the life insurance policy.

11. The insured may be contacted by the viatical/life settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

12. **Ashar Group, LLC** recommends that you read the viatical/life settlement contract and seek assistance from a professional financial advisor and/or consult with your legal advisor prior to signing it.

13. I/we confirm and acknowledge that **Ashar Group, LLC** has provided me/us with a brochure developed and/or approved by the National Association of Insurance Commissioners (NAIC) describing the process of viatical/life settlements.

I/We acknowledge that I/we have read and understand the disclosures above (1-13)

PRINTED NAME	<div style="text-align: center; font-size: 8px; color: #f0e68c; background-color: #fff9c4; padding: 2px; display: inline-block; margin-bottom: 5px;">Please Sign & Date</div> SIGNATURE OF PRIMARY INSURED	DATE
PRINTED NAME	<div style="text-align: center; font-size: 8px; color: #f0e68c; background-color: #fff9c4; padding: 2px; display: inline-block; margin-bottom: 5px;">Please Sign & Date</div> SIGNATURE OF SECONDARY INSURED (if applicable)	DATE
PRINTED NAME	<div style="text-align: center; font-size: 8px; color: #f0e68c; background-color: #fff9c4; padding: 2px; display: inline-block; margin-bottom: 5px;">Please Sign & Date</div> SIGNATURE OF POLICY OWNER #1 (if NOT Insured)	DATE
PRINTED NAME	<div style="text-align: center; font-size: 8px; color: #f0e68c; background-color: #fff9c4; padding: 2px; display: inline-block; margin-bottom: 5px;">Please Sign & Date</div> SIGNATURE OF POLICY OWNER #2 (if NOT Insured)	DATE
PRINTED NAME	<div style="text-align: center; font-size: 8px; color: #f0e68c; background-color: #fff9c4; padding: 2px; display: inline-block; margin-bottom: 5px;">Please Sign & Date</div> SIGNATURE OF AUTHORIZED REPRESENTATIVE OF ASHAR GROUP, LLC	DATE

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PLEASE COMPLETE FOR EACH INSURED

1. Name of Insured:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
2. Insurance Company:	Policy #:	Policy Date:	
Death Benefit \$:	Premiums Paid to Date \$:		
3. Name of Initial Policy Owner (at time of Policy Issuance):			
4. Name of Initial Beneficiaries (at time of Policy Issuance):			
5. Name of Current Policy Owner (if different than question 3 above):			
6. Name of Current Beneficiaries (if different than question 4 above):			
7. What was the Insured's and Policy Owner's original purpose for buying the policy? Please explain in detail. Explanations such as "estate planning" should be expanded upon.			
<hr/> <hr/>			
8. Before or at the time the policy was issued, did the Insured, Policy Owner or any other party arrange to transfer, sell, or assign, directly or indirectly the policy or any benefits to a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe the arrangement in detail and provide copies of any documents relating to the arrangement.			
<hr/>			
9. Has the Insured or Policy Owner ever assigned the policy or policy benefits to any person or entity? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe the financing arrangement in detail and provide copies of any documents related to the arrangement.			
<hr/>			
10. Has the policy or any of the policy premiums been financed by a third party, either through a loan, equity, contribution or otherwise? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe the financing arrangement in detail and provide copies of any documents related to the arrangement.			
<hr/>			
If yes, what is the name of the lender? _____			
If yes, what is the principal loan amount? _____			
If yes, what is the loan maturity balance (payoff amount)? _____			
If yes, what is the loan maturity date? _____			
11. List all persons or entities (including any trust) who have, or have had any direct or indirect ownership or other interest in the policy or its proceeds, including the nature of the interest and the relationship of such person or entity to the Insured. For any entity, please identify all persons that own (or have owned) and, if different, control or manage (or have controlled or managed) that entity. For any trust, include all beneficiaries.			
_____	_____	_____	_____
Name	Nature of Interest	Date and Manner Interest was Obtained	Relationship to Insured
_____	_____	_____	_____
Name	Nature of Interest	Date and Manner Interest was Obtained	Relationship to Insured
_____	_____	_____	_____
Name	Nature of Interest	Date and Manner Interest was Obtained	Relationship to Insured

12. Has the policy's Beneficiary changed since the policy was issued? Yes No

If yes, who was the Beneficiary at the time the policy was issued? _____

If yes, what was their relationship to the Insured? _____

If yes, why was the Beneficiary changed? _____

If yes, who is the current Beneficiary and what is their relationship to the Insured? _____

13. Has the Insured or Policy Owner borrowed money directly or indirectly in connection with the policy? Yes No

If yes, please describe the borrowing arrangement in detail and provide copies of any documents relating to the arrangement.

14. Are any of the interests of the Policy Owner in the policy pledged as security to any person or entity or otherwise encumbered or restricted in anyway? Yes No

15. Prior to completing this application, has the Insured or Policy Owner ever given a person or entity the right or option to purchase the policy or a financial interest in the policy? Yes No





If yes, please describe the option in detail and provide copies of any documents relating to that option.

16. Does the Policy Owner or Insured have knowledge of any information that may be used by the issuing Insurance Carrier to challenge the payment of the policy's death benefit, including whether the Policy Owner at the time of policy issuance had an insurable interest in the life of the Insured? Yes No

If yes, please explain in detail: _____

NEITHER ASHAR GROUP, LLC, NOR ANY REPRESENTATIVE OF ASHAR GROUP, LLC, IS OFFERING LEGAL OR TAX ADVICE IN CONNECTION WITH THE PROPOSED SALE OF THE LIFE INSURANCE POLICY DESCRIBED IN THIS DOCUMENT. EACH OF THE UNDERSIGNED HAS SOUGHT PERSONALIZED ASSISTANCE FROM AN ATTORNEY OR OTHER FINANCIAL PROFESSIONAL IN HIS/HER STATE OF RESIDENCE.

Each of the undersigned Insured, Policy Owner, and Agent hereby certify that the information provided in this questionnaire is true and correct as of the date hereof. Each of the undersigned affirms its understanding that Ashar Group, LLC and its affiliates will be relying on the statements and responses which are being provided by all of the undersigned in the questionnaire, and each of the undersigned agrees, jointly and severally to hold Ashar Group, LLC harmless and agrees to indemnify Ashar Group, LLC from and against any loss, liability, fees (including attorneys' fees) costs, expense, claim or demand arising out of or in connection with any such statement or response.

_____		_____
NAME OF PRIMARY INSURED	SIGNATURE OF PRIMARY INSURED	DATE
_____		_____
NAME OF SECONDARY INSURED (if applicable)	SIGNATURE OF SECONDARY INSURED (if applicable)	DATE
_____		_____
NAME OF POLICY OWNER	SIGNATURE OF POLICY OWNER	DATE
_____		_____
NAME OF REFERRING ADVISOR	SIGNATURE OF REFERRING ADVISOR	DATE

PERSONAL DATA: (PLEASE COMPLETE FOR EACH INSURED)

1. Printed Name: _____		DL/ID #: _____
2. Date of Birth: _____	3. Social Security #: _____	
4. Height: _____ ft. _____ in.	Weight: _____ lb.	5. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Mother's age, if living: _____	If deceased, age at death: _____	Cause of death? _____
Father's age, if living: _____	If deceased, age at death: _____	Cause of death? _____
Sibling's age, if living: _____	If deceased, age at death: _____	Cause of death? _____
Sibling's age, if living: _____	If deceased, age at death: _____	Cause of death? _____
7. With whom do you reside?: <input type="checkbox"/> Spouse <input type="checkbox"/> Relative <input type="checkbox"/> Child <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Friend <input type="checkbox"/> Alone <input type="checkbox"/> Nursing Home		
8. If living with "relative" or "friend", how long have you been living with him/her? _____		
9. If widowed, years since death of spouse: _____		
10. Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, occupation: _____		
11. Have there been any major life changes in the last two(2) years? (Check all that apply) <input type="checkbox"/> Change of employment (include retirement, retirement for health reasons) <input type="checkbox"/> Loss of a family member or friend (include death, divorce and/or separation) <input type="checkbox"/> Change of residence <input type="checkbox"/> Other: _____		
12. If yes to any of these major changes, how long has it been since the event? _____		

LIFESTYLE:

1. Do you currently use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type(s)? _____ Amount per day? _____ <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other		
2. If no current tobacco use, have you ever used tobacco in the past and quit? <input type="checkbox"/> Yes <input type="checkbox"/> Never Used If yes, indicate type, amount used and when quit. Type? _____ Amount per day? _____ How long ago did you quit? _____		
3. Do you currently use Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type(s)? _____ Amount per day? _____		
4. If no current Alcohol use, have you ever used Alcohol in the past and quit? <input type="checkbox"/> Yes <input type="checkbox"/> Never Used If yes, indicate amount used and when quit? Type? _____ Amount per day? _____ How long ago did you quit? _____		
5. Do you participate in social activities outside the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Volunteer <input type="checkbox"/> Attend Social Events <input type="checkbox"/> Participate in Recreational Activities <input type="checkbox"/> Travel <input type="checkbox"/> Play Cards		
6. Do you have a pet? <input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL:

1. Have you ever consulted a doctor, been treated for and/or been diagnosed with any of the following conditions?

(Please check all that apply)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Faintness/Fainting | <input type="checkbox"/> Amputation | <input type="checkbox"/> Bowel/Bladder Disorder |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Broken Bone | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain/Tightening |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Immune System Disorders | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> TB/Lung Disorder | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis _____ (Type) | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Asthma | |

Please provide details on the above checked conditions: (attach separate sheet if necessary)

2. Have you been told that you will need hospitalization, surgery, or nursing home care within the next 12 months? Yes No

If yes, please describe: _____

3. Do you have a family history of any of the following? (Please check all that apply)

- Heart Disease Depression Diabetes Cancer Mental Illness Dementia

4. What prescription medications do you take regularly? (List below and give doses)

_____	_____
_____	_____
_____	_____
_____	_____

5. Non-prescription medicines, alternative treatments, or herbal remedies? (List below and give doses)

_____	_____
_____	_____
_____	_____
_____	_____

FUNCTIONALITY:

1. Can you independently perform the following tasks? (Check all "yes" responses)

- | | | | |
|----------------------------------|--|--|--|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Handling Finances | <input type="checkbox"/> Meal Planning | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Shopping | <input type="checkbox"/> Toileting | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Take Medications | <input type="checkbox"/> Walking | <input type="checkbox"/> Using the Telephone |

2. Do you use any device to assist you? (Check all that apply)

- Cane Crutches Wheelchair Walker Other: _____

3. Have you fallen or had any household accidents in past 2 years? Yes No

If yes, please describe and indicate duration of time you were down on the ground/floor: _____

4. Do you currently drive? Yes No

If yes, how often? Daily Weekly Monthly

5. Did you fill out this questionnaire yourself? Yes No

If no, Who helped you? _____

I certify that the information contained in this assessment is accurate and correct. I understand that the information I have provided will be used as the basis for significant decisions, including financial decisions. Falsification of this assessment in any detail is grounds for disqualification from further consideration and gives the purchaser and its agents and representatives the right to void any contract, settlement or other agreement based, in whole or in part, on the information provided in this assessment.

Please Sign
& Date

NAME OF INSURED

SIGNATURE OF INSURED

DATE

Please Sign
& Date

NAME OF PERSON WHO COMPLETED THIS FORM
(IF OTHER THAN INSURED)

SIGNATURE OF PERSON WHO COMPLETED THIS FORM
(IF OTHER THAN INSURED)

DATE

Authorization for the Release of Life Insurance Policy Information (PLEASE COMPLETE FOR EACH POLICY)

LIFE INSURANCE COMPANY	POLICY NUMBER
PRINTED NAME OF PRIMARY INSURED	PRINTED NAME OF SECONDARY INSURED (IF APPLICABLE)
PRINTED NAME OF POLICY OWNER #1 (INCLUDING TRUSTEES)	PRINTED NAME OF POLICY OWNER #2 (INCLUDING TRUSTEES)
PRINTED NAME OF POLICY OWNER #3 (INCLUDING TRUSTEES)	PRINTED NAME OF POLICY OWNER #4 (INCLUDING TRUSTEES)

I/we (the undersigned individual(s)) hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy to release such information to and reply immediately to any written, e-mail, telephonic or other request for information or documents required by **Ashar Group, LLC** and/or its affiliates, successors, assigns and authorized representatives (“**Ashar Group, LLC**”) relating to the above-referenced life insurance policy.

I/we authorize the release of information by this form pertaining to the above-referenced life insurance policy to include but not be limited to the following:

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ Original copy of the policy ■ Applications for insurance ■ Riders ■ In-force illustrations, including projections of values in the future ■ Conversions ■ Withdrawals ■ Lapse or reinstatement status | <ul style="list-style-type: none"> ■ Verification of coverage ■ Change in ownership and beneficiary confirmation/designation ■ Absolute or collateral assignment ■ Premium payments and payment provisions ■ Contestable and suicide status ■ Any and all other information |
|---|---|

In addition, I/we authorize **Ashar Group, LLC** to share the information it receives from the life insurance company to any other person or entity, including the affiliates of each, required or compelled by law to receive or view such information to evaluate all of my/our options related to the above referenced policy. **Ashar Group, LLC** shall not release such information to any person or entity except as referenced above.

I/we authorize and request that this Authorization shall remain valid until the death of the Insured (or if multiple Insureds, until the death of the last to survive), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. I/we further authorize that a photocopy, PDF or electronic file or facsimile of this Authorization is as valid as an original.

I/we certify that a) I/we am/are executing and delivering this Authorization freely and unilaterally/collectively as of the date written below; and b) I/we have a full understanding of the Authorization’s contents.

Authorized By:

PRINTED NAME	SIGNATURE OF PRIMARY INSURED	DATE
PRINTED NAME	SIGNATURE OF SECONDARY INSURED (if applicable)	DATE
PRINTED NAME	SIGNATURE OF POLICY OWNER #1 (if NOT Insured)	DATE
PRINTED NAME	SIGNATURE OF POLICY OWNER #2 (if NOT Insured)	DATE
PRINTED NAME	SIGNATURE OF POLICY OWNER #3 (if NOT Insured)	DATE
PRINTED NAME	SIGNATURE OF POLICY OWNER #4 (if NOT Insured)	DATE

Authorization for the Disclosure of Protected Health Information (PLEASE COMPLETE FOR EACH INSURED)

I, _____ (the undersigned individual), DOB _____ SS# _____, hereby authorize disclosure, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, of my protected health information (“PHI”) as follows:

1. **Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, 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. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. **Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Ashar Group, LLC** including any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each, and to any other person or entity required or compelled by law to receive or view such PHI to evaluate, monitor, facilitate, underwrite, solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, brokers/brokerages, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and its or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (each, an “Authorized Recipient”). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
3. **Description of PHI 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. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing an Authorized Recipient to (1) 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; and (2) 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 an Authorized Recipient, or any other person or entity, purchases. In addition, I acknowledge that some state and federal laws prohibit the further disclosure of drug, alcohol or HIV related information without specific written consent. This authorization shall serve as such consent in order for each Authorized Recipient to perform the functions described herein.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.
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 my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that a) 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”); b) 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 re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations; and c) my ongoing health status may be tracked as a result of this Authorization.

I certify that I am executing and delivering this authorization freely and unilaterally 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.

Authorized by:

PRINTED NAME	SIGNATURE OF INSURED	DATE
PRINTED NAME	SIGNATURE OF LEGAL REPRESENTATIVE (if any)	DATE
DESCRIPTION OF LEGAL REPRESENTATIVE'S AUTHORITY (if any):	(POA, GUARDIAN AD LITEM OR SIMILAR STATUS—PLEASE ATTACH LEGAL DOCUMENTS FOR VERIFICATION)	