BEACON
LIFE FUNDS

Viatical/Life Settlement Inquiry Checklist and Instructions:

The following completed and signed forms are required by Beacon Life Funds to obtain settlement offers. Please contact one of our counselors for assistance at 1-855-542-4552:

1. Confidential Information and Authorization – pages 1 & 2
2. Authorization for Release of Medical Information
3. Authorization for Release of Policy Information
4. Notice of Disclosure

The forms can be transmitted to Beacon as follows:

Mail to:

Beacon Life Funds

1245 S. Michigan Avenue, #232

Chicago, IL 60605

The original signed documents are required to obtain settlement offers. However, in addition to mailing the documents, you can scan and email or fax the documents, using the information below so we can get started right away.

A copy of the insured's insurance policy must also be received before settlement offers can be made, so consider mailing that along with your original signed documents.

Scan & email to:

mpaul@beaconlifefunds.com

Fax:

(312) 722-6638

BEACON LIFE FUNDS

1-855-542-4552

CONFIDENTIAL INFORMATION AND AUTHORIZATION

INSURED'S INFORMATION

Insured's Name: _____ Sex: Female ☐ Male ☐

DOB: ____/____/_____ SSN: _____ _____ _____

Address: *(No PO Box)*: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Addresss: _____

BENEFICIARY INFORMATION

Beneficiary Name: _____ DOB: _____/_____/_____

Relation to Insured _____ SSN: _____

EMERGENCY/ALTERNATE CONTACT:

Contact: _____ Relation to Insured _____

Email address: _____ Phone #: _____

OWNER INFORMATION

Policy Owner: _____ State of Residence _____

Trust or Corporation name, and names of Trustee(s) or 2 officers _____

_____

Owner S.S. or Tax ID # _____ Phone: _____ Fax: _____

Since this policy has been in force, has owner been a party to a: [check all that apply]

Civil Suit O D, Bankruptcy O D, Judgments O D, Creditor Liens O D, Tax Liens O D, Divorce O D

Explain any checked answers on a separate page and attach all discharge papers.

Reason for selling policy:

_____

LIFE INSURANCE POLICY INFORMATION *(for each policy being offered for sale, separate sheet ok)*

Ins. Company: _____ Policy Number: _____ Issue Date _____

Face Value $ _____ Current Cash Value $ _____

Cash Surrender Value $ _____ Loans $ _____ Policy Type:

□Individual O D, □Universal O D, □Term O D, □Whole Life O D, □Group OD, □FEGLI OD

Premium $ _____ Paid A OD, SA OD, Q O D, M OD, Next due date _____

BEACON
LIFE FUNDS

1-855-542-4552

INSURED'S MEDICAL INFORMATION

List any specific health conditions:

_____

_____

Insured's Primary Care Physician(s):

Name: _____ Name: _____
Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Date of last consultation: _____ Date of last consultation: _____

List any Specialist that insured has seen:

Name: _____ Name: _____

Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Date of last consultation: _____ Date of last consultation: _____

PERSONAL ACKNOWLEDGEMENT

I represent and warrant that the information contained herein is correct and accurate and may be relied thereon and that I will immediately notify Beacon Life Funds of any subsequent changes. I hereby authorize Beacon Life Funds information for the sole purpose of soliciting the purchase of my life insurance policy(ies). I acknowledge that I am submitting this authorization and information for Beacon Life Funds to act as a broker on my behalf. I acknowledged that Beacon Life Funds will submit my policy(ies) to various licensed providers to evaluate the purchase of my life insurance policy(ies), and that Beacon Life Funds is not liable for any representations, warranties, or misconduct on the part of any licensed provider or independent representatives. I acknowledge I may be contacted by Beacon Life Funds regarding the information contained herein.

I understand that some or all of the proceeds from a life settlement may be taxable and that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that Beacon Life Funds nor any of its agents, affiliates, or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

Owner's signature: _____

Typed or printed name: _____ Date: __/__/____

Insured's signature (if not the owner): _____

Typed or printed name: _____ Date: __/__/____

BEACON
LIFE FUNDS

1-855-542-4552

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(HIPAA Compliant)

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically-related facility, insurance supported organization, pharmacy, or any other institution or person ("Authorized Discloser") to provide Beacon Life Funds or its designee ("Authorized Recipient"), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me (hereinafter, "Protected Health Information" or "PHI").

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 treatment of the patient, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the patient, along with any and all medical charts, clinical or doctor's notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in the possession and control of the Authorized Discloser.

By signing below, I understand that this Authorization shall apply to any and all PHI, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I further understand that PHI obtained may be used to evaluate eligibility to participate in Purchaser's life settlement program and to evaluate life expectancy now and in the future. Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this Authorization.
I agree that a photocopy or facsimile is as valid as the original.

I agree that this Authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

I understand that I may revoke this Authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of the revocation in writing and delivering such revocation by certified mail or personal delivery at such address designated by the respective Authorized Discloser.

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"), and that PHI obtained by this Authorization, if re-disclosed by authorized Designee, may no longer be protected by the HIPAA Privacy Regulations.

INSURED

_____ _____

Signature of Insured | Printed Name of Insured

_____/_____/_____ _____/_____/_____

Date | Social Security Number

BEACON
LIFE FUNDS

1-855-542-4552

AUTHORIZATION FOR THE RELEASE OF INFORMATION
RELEASE OF POLICY INFORMATION

I hereby authorize _____, the issuer of Policy Number _____ and/or Certificate Number _____ owned by _____ and insuring the life of _____, to release to Beacon Life Funds, its authorized agents, life settlement brokers/providers and/or underwriters a copy of the policy, forms, riders or amendments, illustrations, premium history or verification of coverage of this policy. I understand that funding sources and their underwriters and/or contingency re-insurers will use such information for the purposes of pursuing and/or completing the sale of these life insurance policy(ies). I agree that a photocopy or facsimile of this authorization is as valid as the original.

_____ _____
Signature of Owner Printed Name of Owner

_____ _____
Date Signed Social Security Number

BEACON
LIFE FUNDS

1-855-542-4552

NOTICE OF DISCLOSURE

1. There may be alternatives to a life settlement contract including, but not limited to, accelerated benefits, loans secured by the policy, and surrender of the policy for cash value offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. We encourage you to contact the issuer of your policy to discuss these other benefits.
2. Some or all of the proceeds of your life settlement may be taxable under federal income tax and/or state franchise and income tax laws. Beacon Life Funds strongly urges you to consult your own attorney or tax advisor concerning this transaction. Beacon Life Funds makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of your life settlement proceeds may adversely affect your eligibility for social security income, public assistance, public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Proceeds from a life settlement may not be exempt from claims of creditors, personal representatives, or trustees in bankruptcy and receivers in state or federal court.
5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents or others, there may be a loss of coverage. Beacon Life Funds urges you to contact the issuer of your life insurance policy for information on these provisions.
6. Entering into a life settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other rights or benefits, including conversion rights and waiver or premium benefits that may exist under the policy to be forfeited by you.
7. All medical, financial, or personal information solicited or obtained by Beacon Life Funds regarding 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 life settlement between you and Beacon Life Funds. If the insured is asked to provide this information, the insured 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. The insured may be asked to renew his or her permission to share information every two years.
8. The insured may be contacted by Beacon Life Funds or its authorized representative(s) 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.
9. I understand that the settlement provider is legally required to send me funds within three (3) business days after they have received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred **and** the new beneficiary has been designated.
10. I acknowledge Beacon Life Funds is to be compensated by the buyer in the amount of 6% of the policy face amount on all Viatical Settlements.
11. How did you hear about us: □ Internet Search (Google, Bing, other: _____); □Magazine: _____; □ Medical Provider (City/State): _____; Personal Reference: _____; or □ Other: _____.

I acknowledge that I have read and understand the contents of this disclosure.

INSURED

Signature: _____ SSN: _____/_____/_____

Printed Name: _____ Date: _____/_____/_____

OWNER (if other than insured)

Signature: _____ SSN: _____/_____/_____

Printed Name: _____ Date: _____/_____/_____