Agent of Record Agreement

To Whom It May Concern,

I/We the undersigned appoint Confidential Life Settlements and any of its successors and assigns and affiliate entities as the exclusive Agent of Record for the Policy(ies) listed below for the purpose of negotiating the sale of the Policy(ies) as a Life Settlement. The undersigned agrees not to appoint any other individual nor entity or revoke this Agent of Record Agreement for a period of six (6) months from the date of this agreement with respect to the Policy(ies) shown. Written notice of such revocation must be provided to Confidential Life Settlements. All offers obtained by Confidential Life Settlements from licensed providers (buyers) will be processed exclusively through Confidential Life Settlements for a period of twelve (12) months from the date of this agreement. All offers will be provided to the undersigned. All Agent of Record agreements signed by me/us prior to the date of this Agent of Record agreement are null and void. I/We agree that a photographic copy or facsimile of this Agent of Record agreement shall be valid as the original.

Authorized Signature of Insured	Authorized Signature of Policy Owner
Printed Name of the Signatory	Printed Name of the Signatory
Social Security Number	Social Security Number
Date Signed	Date Signed

Insured Name(s):	Policy Number:	Insurance Carrier:

Gene Pleasants • 3820 Merton Drive, Suite 100, Raleigh, NC 27609 • 919-256-6521 • Mobile 919-418-8170

Revised 12/04/06

Authorization for Disclosure of Protected Health Information

I, the undersigned, authorize 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, 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 Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Confidential Life Settlements, Inc. and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").
3. 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. This authorization and all disclosures of my PHI made under this authorization are for purposes of 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 the 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, including any conversions thereof.
4. Expiration: This authorization shall remain valid until, and shall expire, 30 months after the date of my death.
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.

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 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.

____

Name of Proposed Insured (*Please Print*)

______________________________ ______________

Signature of Proposed Insured or Personal Representative Date

____

Name of Submitting Agent

______________________________ ______________

Signature of Submitting Agent Date

Gene Pleasants • 3820 Merton Drive, Suite 100, Raleigh, NC 27609 • 919-256-6521 • Mobile 919-418-8170

Revised 12/04/06

Life Insurance Information Release Form

Life insurance policy number ______________________ issued by ____________________________________

(Insurance Company), is owned by ____, and insured the life of

____ .

I authorize the release to Confidential Life Settlements, Inc. or its designee, any or all information concerning the above policy.

I authorize Confidential Life Settlements, Inc. to share this information with Life Settlement Providers and other parties, as required.

____

Name of Policy Owner (*Please Print*)

____ _________________________

Signature of Policy Owner Date

____

Name of Submitting Agent

____ _________________________

Signature of Submitting Agent Date

Gene Pleasants • 3820 Merton Drive, Suite 100, Raleigh, NC 27609 • 919-256-6521 • Mobile 919-418-8170

Revised 12/04/06

Life Settlement Evaluation Form

(*Please print or type*)

A. PERSONAL INFORMATION

Insured's Name ______ Date of Birth ______ Social Security Number ______

2nd Insured's Name ______ Date of Birth ______ Social Security Number ______

Address ______ Phone Number ______

City ______ State ______ ZIP ______

Reason for Sale ______ Has the insured ever declared bankruptcy? Yes ___ No ___

Insured marital status: Single/Never Married ___ Married ___ Widowed ___ Divorced ___

If policy is owned by another person or a trust please complete the following. Otherwise, skip down to ***B. Life Insurance Information***.

Name of trustee, policy owners or corporation ______

Tax Number of owner/s ______

If owned by a trust or corporation, legal name ______ Date of formation ______

Address of Policy Owner ______ Phone Number ______

City ______ State ______ ZIP ______

Has the Policy Owner ever declared bankruptcy? Yes ___ No ___

If the Policy Owner is an individual give marital status: Single/Never Married ___ Married ___ Widowed ___ Divorced ___

B. LIFE INSURANCE INFORMATION

Insurance Company ______ Policy Number ______ Face Amount ______

Date of Issue ______ Policy Type *(WL, UL, SUL, Term, etc.)* ______ Current Premium ______

Policy Loan Amount (if any) ______ Policy Cash Value Amount (if any) ______

Policy Owner ______ State of Residence ______

Beneficiary(s) ______

C. MEDICAL INFORMATION

Insured's Medical History ______

______

______

______

______

______

Primary Physician ______ Telephone Number ______

Specialist ______ Telephone Number ______

Specialist ______ Telephone Number ______

Specialist ______ Telephone Number ______

Gene Pleasants • 3820 Merton Drive, Suite 100, Raleigh, NC 27609 • 919-256-6521 • Mobile 919-418-8170
Fax 919-834-7936 or 1- 800-606-2243

Insured's Name: ______________________________

Life Settlement Evaluation Form

The undersigned represents to Confidential Life Settlements, Inc., hereinafter referred to as The Company, that:

A. The information contained herein is complete and accurate and may be relied upon by The Company, Life and Settlement/Viatical Settlement Providers and Financing Sources.

B. The undersigned will immediately notify The Company of any material change in any information contained herein, occurring prior to conclusion of the proposed sale, including but not limited to: cancellation and release of insurance policies, assignment of ownership of policies, change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies.

The proposed sale, cancellation and release of insurance policies, assignment of ownership of policies, or change in beneficiary and irrevocable assignment of right to designate future beneficiaries of policies will be solely for the benefit and account of the undersigned, and not for the account or benefit of any other person.

FRAUD WARNING

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

NOTICE TO APPLICANTS

Neither The Company, it's officers, directors, principals, nor employees provide legal, accounting, or financial advice to prospective applicants regarding the advisability or relative merits of selling or conveying their legal rights in existing life insurance policies in exchange for cash payments referred to as living benefits, viatical settlements, intervivos settlements, or other similar terms.

An applicant must determine the relative benefit of any such living benefit settlement after review of the legal and financial implications of such a settlement with the applicant's own attorney, accountant, or other appropriate advisors, only then, should a decision be made to effect such a sale or settlement.

Applicant has a clear & complete understanding of the current or future benefits of the life insurance policy being offered for sale or settlement.

Applicant acknowledges that he/she has freely and voluntarily provided the information requested in this application.

PLEASE SEND WITH THE COMPLETE APPLICATION FORM, PHOTOCOPIES OF THE FOLLOWING:

A. Life Insurance policy to be sold, including the application for insurance

B. Your Driver's License

C. Social Security Card

______________________________	______________________________	____________________
Applicant's Full Name (Type or Print)	Applicant Signature	Date
______________________________	______________________________	____________________
Witness' Full Name (Type or Print)	Witness Signature	Date

Gene Pleasants • 3820 Merton Drive, Suite 100, Raleigh, NC 27609 • 919-256-6521 • Mobile 919-418-8170
Fax 919-834-7936 or 1- 800-606-2243