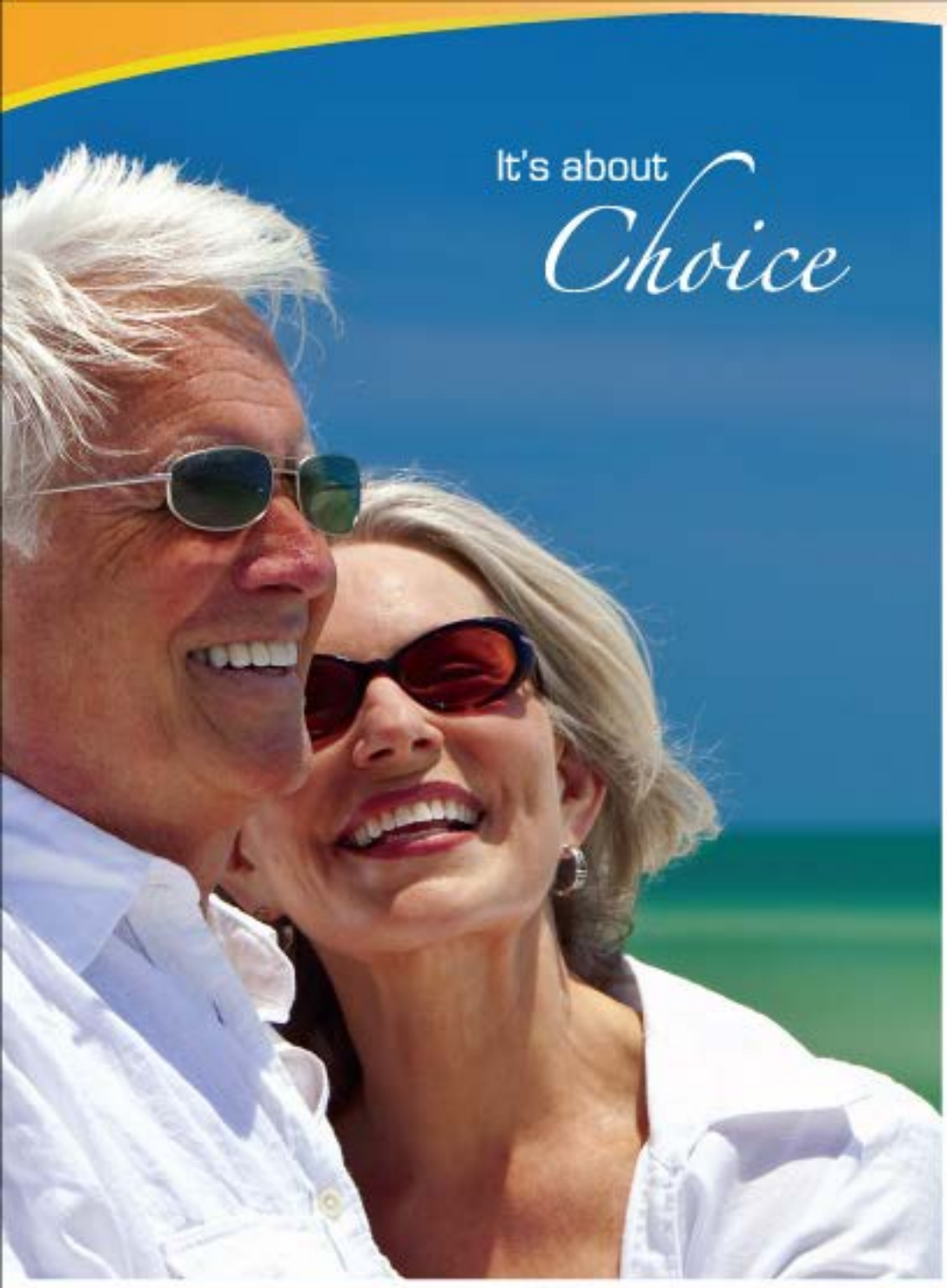


WELCOME FUNDS

Life Settlements. Simplified.®

ALASKA
STATE APPLICATION

WELCOME FUNDS INC.
4775 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
FAX: 561.862.0242
WWW.WELCOMEFUNDS.COM

A LETTER FROM THE FOUNDER

Dear Policy Owner/Insured:

As Founder & CEO of Welcome Funds, I would personally like to thank you for considering our team to serve as your personal representative in the secondary market for life insurance. We understand that you have choices in this process and we appreciate the opportunity to represent you. We also know that selling your life insurance policy is an important financial decision for you and your family, and our goal is to ensure that you are able to make this choice with confidence.

Welcome Funds is the one of the oldest and largest life settlement brokers in the United States and has assisted thousands of Americans since our founding in 2000. As your broker, we work diligently to represent your best interests during the entire transaction, from initial evaluation through the closing process. Our procedures consist of the following:

- Initial evaluation and review to determine eligibility;
- Evaluation Request assessment and processing;
- Medical records requests and life insurance policy verifications;
- Obtaining independent third party life expectancy report(s);
- Submission to authorized and/or state licensed secondary market buyers of life insurance policies;
- Best execution negotiations via an auction process in an effort to maximize the sales price of your policy;
- Closing services including contract review and assistance with closing contingency requirements.

In addition to the traditional procedure and lump sum cash settlements offered by the secondary market, we are also able to provide alternative options that you may want to consider, depending on your personal needs:

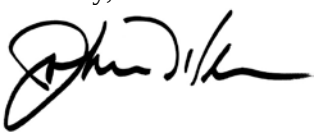
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the buyer paying all future premiums. This can include a combination of a cash payout & retaining a portion of the death benefit. This option may not be available in all states or for all policies; or
3. **Life Insurance Loans** – if you are interested in a loan using your life insurance policy as collateral, we can also work with multiple lending firms to secure financing. A loan option may not be available in all states or for all policies.

Please be sure to inform your advisor or your case manager if you would like to consider any of the above options. We would also like to recommend that you discuss the tax consequences of selling your life insurance policy with a tax advisor, as it is likely a taxable event, unless the insured qualifies for a viatical settlement or long-term care exemption in compliance with IRS codes. Additionally, we have attached a brief brochure for your review issued by the National Association of Insurance Commissioners to provide an unbiased, independent description of selling policies in the secondary market.

As a reminder, you are under no obligation to sell your life insurance policy, in fact, if you need your coverage and can afford to maintain it, we highly recommend that you do so!

Once again, thank you for allowing us the opportunity to help you reach your financial goals and to represent you in the secondary market for the potential sale of your life insurance policy.

Sincerely,



John M. Welcom
Founder & CEO

WELCOME FUNDS INC.
d/b/a WFI LIFE INSURANCE SERVICES
4755 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

TOLL-FREE: 877.227.4484 PHONE:
561.862.0244
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WWW.WELCOMEFUNDS.COM

State of Alaska

Viatical Settlements Broker License

State of Alaska Insurance License

License No: 100159143

NPN: 3421401

WELCOME FUNDS INC.

4755 Technology Way
Suite 202
BOCA RATON FL 33431

This is to certify that pursuant to requirements of the Alaska Division of Insurance Code the above named is qualified to do business in the state of Alaska with the authority listed below.

CLASS	ISSUE DATE	EFFECTIVE DATE	EXPIRE DATE	LINES OF AUTHORITY
Insurance Producer	04/19/2018	04/20/2024	04/19/2026	Health, Life, Variable Life and Variable Annuity
Viatical Settlement Broker	03/11/2020	03/12/2024	04/19/2025	Health, Life, Variable Life and Variable Annuity

This license is expressly conditioned upon the holder being in full compliance with all of the applicable laws and requirements made under authority of the laws of the State of Alaska and as such laws and requirements may hereafter be changed or amended. Your license will expire/lapse on the above indicated date. You must renew your license prior to this date to continue transacting the business of insurance in Alaska.

For questions regarding licensing, renewal, or continuing education requirements, contact the Alaska Division of Insurance or visit http://www.commerce.state.ak.us/insurance

LORI K. WING-HEIER

VOID IF ALTERED NON-TRANSFERABLE

WELCOME FUNDS INC.
4775 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

This request is not an agreement to purchase your policy and you are under no obligation to sell your policy by completing this form. The information that you provide in this request shall be used to evaluate and prepare your file, as required, to attempt to negotiate and secure a conditional offer or offers for the potential sale of your existing life insurance policy.

PRIMARY INSURED'S INFORMATION

PRIMARY INSURED NAME (FULL LEGAL NAME) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** | **TELEPHONE NUMBER**

CURRENT HOME ADDRESS | **CITY** | **STATE** | **ZIP CODE**

PRIMARY ATTENDING PHYSICIAN | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced – Date: _____

PLEASE CHECK APPICABLE MARITAL STATUS | **IF MARRIED/DIVORCE/WIDOWED, FULL NAME OF (EX)SPOUSE**

SECONDARY INSURED'S INFORMATION (If Applicable – 2ND To Die / Survivorship Policies Only)

SECONDARY INSURED NAME (FULL LEGAL NAME) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** | **TELEPHONE NUMBER**

CURRENT HOME ADDRESS | **CITY** | **STATE** | **ZIP CODE**

PRIMARY ATTENDING PHYSICIAN | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

☐ Family Member ☐ Spouse ☐ Business Partner ☐ Other:_____

PLEASE CHECK APPICABLE RELATIONSHIP TO PRIMARY INSURED (IF APPLICABLE)

If there are additional physicians or medical information, then please attach a separate sheet with complete details.

LIFE INSURANCE POLICY INFORMATION

LIFE INSURANCE COMPANY | **FACE AMOUNT** | **POLICY NUMBER** | **ISSUE DATE**

☐ YES ☐ NO

POLICY LOAN AMOUNT (IF ANY) | **ACCUMULATED/CASH VALUE** (IF ANY) | **CASH SURRENDER VALUE** (IF ANY) | **CASH VALUE USED TO PAY PREMIUMS?**

☐ Individual ☐ Joint Survivorship ☐ Group ☐ Other: _____

TYPE OF POLICY (PLEASE CHECK ONE)

IF A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP OR YOUR HR DEPT. CONTACT

☐ Term ☐ WL ☐ UL ☐ Other: _____

CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly $_____

POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX) | **PREMIUM AMOUNT**

PLEASE PROVIDE NAMES AND RELATIONSHIP OF ALL PRIMARY BENEFICIARIES OF POLICY (IF IT IS A TRUST, PROVIDE TRUST NAME AND NAME & ADDRESS OF TRUSTEE(S))

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

If Individually Owned *(if Insured is 100% Owner, skip to Bankruptcy Status):*

LEGAL NAME OF POLICY OWNER # 1 | **RELATIONSHIP TO INSURED** | **SOCIAL SECURITY NUMBER**

POLICY OWNER # 1 ADDRESS | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

LEGAL NAME OF POLICY OWNER # 2 (IF APPLICABLE) | **RELATIONSHIP TO INSURED** | **SOCIAL SECURITY NUMBER**

POLICY OWNER # 2 ADDRESS | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

IF THERE ARE MORE INDIVIDUAL POLICY OWNERS, THEN PLEASE LIST ALL NAMES AND STATES OF RESIDENCE

☐ Family Member ☐ Spouse ☐ Business Partner ☐ Policy Owner is Insured ☐Other: _____

IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK APPICABLE RELATIONSHIP TO INSURED

☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced – Date: _____

IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK MARITAL STATUS

☐ YES ☐ NO ☐ YES ☐ NO Date:_____

HAS A POLICY OWNER EVER DECLARED BANKRUPTCY? | **IF SO, HAS IT BEEN DISCHARGED?** | (PLEASE PROVIDE ALL BANKRUPTCY DOCS) | **WHEN WAS IT DISCHARGED?**

If Corporate or Trust Owned:

LEGAL NAME OF COMPANY OR TRUST | **RELATIONSHIP TO INSURED** | **TAX ID NUMBER**

COMPANY OR TRUST ADDRESS (OFFICIAL DOMICILE) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 1 | **LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 2**

TRUSTEE # 1 ADDRESS (IF DIFFERENT THAN TRUST) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

TRUSTEE # 2 ADDRESS (IF DIFFERENT THAN TRUST) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

For multiple policies, please reprint this page, then complete the above information and sign an insurance authorization form for each policy.

ADDITIONAL INFORMATION

PLEASE PROVIDE REASONS FOR INTEREST IN SELLING POLICY(IES), CHECK ALL THAT APPLY:

- ☐ Planning to lapse, cancel, or surrender the policy
- ☐ Health & living expenses are a financial burden
- ☐ Premium costs have become unaffordable
- ☐ Original purpose of policy no longer exists
- ☐ Other or provide further details: _____
- ☐ Proceeds from sale will help pay for medical treatments
- ☐ Considering a 1035 Exchange or replacement policy
- ☐ Cash liquidity preferred due to current financial situation
- ☐ Higher estate tax exemptions has eliminated need for policy

PLEASE VERIFY LEGAL CAPACITY OF POLICY OWNER(S) & INSURED(S):

If you choose to accept a contingent offer as a result of this preliminary application process, each individual Policy Owner(s) and Insured(s) may be required to have a Letter of Competency completed by an attending physician in order to verify their legal capacity to enter into an agreement to sell the life insurance policy. If the legal capacity of any party is questionable, we recommend obtaining an official Power of Attorney or Guardian ad Litem for that signatory as soon as possible.

Is there an existing Power of Attorney (POA) granting a legal representative the authority to act on behalf of a signatory or is there a Guardian ad Litem or similar legal representative acting on their behalf regarding this Evaluation Request & Potential Transaction?

Primary Insured: ☐ Yes ☐ No
Secondary Insured (if applicable): ☐ Yes ☐ No
Policy Owner #1 (if not insured): ☐ Yes ☐ No
Policy Owner #2 (if applicable): ☐ Yes ☐ No

If **Yes**, then please:

1) provide a full copy of the applicable legal documents (Durable POA or Medical POA) to verify the authority to sign on behalf of the signatory;
2) have the legal representative sign all signature lines for that party; and
3) provide the names of such legal representative(s) below:

_____
Name of **Legal Representative of Primary Insured** (if applicable)

_____
Name of **Legal Representative of Policy Owner #1** (if applicable)

_____
Name of **Legal Representative of Secondary Insured** (if applicable)

_____
Name of **Legal Representative of Policy Owner #2** (if applicable)

PLEASE VERIFY SOURCE OF PREMIUM PAYMENTS AND/OR ASSIGNMENT OF POLICY:

1) Did the policy owner use a third-party to finance the premium payments? ☐ Yes ☐ No

   If **Yes**, then please:

   a) attach all loan documents, including contracts, trusts and/or corporate documents; and

   b) provide the name of the lender/financing company: _____
   Name of **Lender/Financing Company**

2) Is the life insurance policy being used as collateral for a loan or is there a current lien or assignment recorded with the life insurance carrier?

   ☐ Yes ☐ No

   If **Yes**, please provide all loan documents & name of lienholder/assignee: _____
   Name of **Lienholder/Assignee**

PLEASE VERIFY YOUR MARKET REPRESENTATION:

Are you working with any other third-party, other than Welcome Funds, related to the potential sale of your life insurance policy?

☐ Yes ☐ No

If **Yes**, please check all that apply:

☐ Financial Advisor ☐ Life Agent ☐ Attorney/CPA ☐ Settlement Broker ☐ Direct Buyer ☐ Direct Lender

PERSONAL ACKOWLEDGEMENTS

A. I/We represent that the information contained in this Evaluation Request for Sale of Existing Life Insurance is correct and accurate and acknowledge that WELCOME FUNDS INC may rely on such information as my/our broker for the potential sale of my/our life insurance policy. I/we also acknowledge that it is my/our responsibility to notify WELCOME FUNDS INC of any changes to this information, including any changes in health of the insured after this form has been submitted.

B. I/We understand that the market value of my/our life insurance policy is based in part on the health status and life expectancy of the insured. Current medical records for the insured are vital to obtain life expectancy assessments. These assessments are conducted by independent third-party life expectancy providers as required by the marketplace. WELCOME FUNDS INC is not responsible for the conclusions of these life expectancy providers and does not have the expertise to dispute those conclusions.

C. I/We acknowledge that WELCOME FUNDS INC is my/our broker who represents my/our best interests during the entire transaction process. I/We also understand and acknowledge that WELCOME FUNDS INC issues no guarantee that an offer will be secured for my/our policy.

D. I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial, insurance, medical and personal information gathered from this Evaluation Request for Sale of Existing Life Insurance, including but not limited to medical records, notes and lab reports pertaining to the insured's health, to the appropriate parties who have an identifiable need to review the information.

E. I/We acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my/our contract for the sale of my/our existing life insurance policy if my/our policy is purchased. In addition, I/we have been advised that I/we may obtain a copy, upon request, of any written agreement that I/we enter into regarding or relating to the sale of my/our existing life insurance policy(ies).

F. I/We acknowledge that I/we have been provided the following address/department to direct any consumer complaints that I/we may have: WELCOME FUNDS INC c/o Customer Complaints, to 4775 Technology Way – Suite 202, Boca Raton, FL 33431.

G. I/We understand and acknowledge that WELCOME FUNDS INC does not provide any advice as to whether or not to proceed with the sale of my/our life insurance policy and I/we are free to accept or decline any offer.

H. I/We understand and acknowledge that the policy owner is fully responsible for the timely payment of any and all premiums due for the policy that is the subject of this potential transaction, on the applicable due dates, up until change of ownership of the policy occurs, if a transaction is effectuated. I/We, not WELCOME FUNDS INC, assume sole responsibility if the policy lapses for failure to make timely payment of any and all premiums.

I. I/We would like to consider the following options in addition to a lump sum cash settlement offer (*subject to availability based on state residency, policy types and qualification requirements*):

☐ Retained Death Benefit (RDB) ☐ Cash Settlement with RDB ☐ Life Insurance Loan/Credit Line

☐ Expedited Bid Program (*may require additional disclosures*)

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.

I/We acknowledge that I/we have read and understand the information provided above.

Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if not Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if applicable & if not Insured)	Printed Name	Date

WELCOME FUNDS INC.
4775 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

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PHONE: 561.862.0244
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ALASKA -- NOTICE OF DISCLOSURE

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 and may be subject to fines and confinement in prison.

1. **Welcome Funds Inc.** 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 **Welcome Funds Inc.** and your referring advisor, if any, is compensated.

2. Some or all of the proceeds of your viatical/life settlement contract may be taxable under federal income tax or state franchise or income tax laws. **Welcome Funds Inc.** 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 contract proceeds could be subject to the claims of creditors.

5. There may be possible alternatives to selling your life insurance policy. Alternatives 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 within fifteen (15) days after the date of receipt of the proceeds from a viatical/life settlement contract pending return of the proceeds.

7. Proceeds from a viatical/life settlement contract will be sent to you within three (3) working days after the viatical/life settlement provider receives the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred to the viatical/life settlement provider and the beneficiary under the viatical/life settlement contract has been designated. **Welcome Funds Inc.** 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. You have the right to know the name, business address, and phone number of the independent trustee or escrow agent that is to be used in the viatical/life settlement transaction, along with a statement that you may inspect or receive copies of the relevant agreements or documents provided by the trustee or escrow agent.

9. 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. Assistance should be sought from a professional financial advisor.

10. You have the right to know the name, address and telephone number of the viatical/life settlement provider.

11. Total compensation payable to **Welcome Funds Inc.** 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 = Gross Purchase Price (GPP) as paid by the viatical/life settlement provider reduced by the total compensation as described above. Such actual compensation shall be disclosed prior to executing the contract for the sale of your policy.

[Additional disclosures are on the following page]

ALASKA -- NOTICE OF DISCLOSURE [PAGE 2 OF 2]

12. All medical, financial and personal information solicited or obtained by a viatical/life settlement provider, **Welcome Funds Inc.**, other viatical/life settlement brokers and/or a viatical/life settlement representative about you, including your identity and the identity of your family members, spouse, or spousal equivalent is confidential unless such disclosure is a) necessary to effectuate the viatical/life settlement contract between you and the viatical/life settlement provider and you have provided prior written consent to release the information; or b) provided in response to an investigation or examination by the director (of the State of Alaska). The information may be provided to the financing entity that buys the policy or provides funds for purchase. Check your viatical/life settlement contract to see if and when your permission to share this information may be requested for renewal.

13. By entering into a viatical/life settlement contract, information regarding your identity and 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.

14. By entering into a viatical/life settlement contract, medical, financial and personal information solicited or obtained by a viatical settlement provider, , other viatical/life settlement brokers and/or a viatical/life settlement representative about you, including your identity and the identity of your family members, spouse, or spousal equivalent may be provided to viatical/life settlement financing entities.

15. The insured may be contacted by the viatical/life settlement provider or **Welcome Funds Inc.** or the viatical/life settlement 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 (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

16. Please be advised that providing false or misleading information in order to obtain an insurance policy is insurance fraud under Alaska law (AS 21.36.360).

17. I/we confirm and acknowledge that **Welcome Funds Inc.** has provided me/us with Appendix A: Selling Your Life Insurance Policy as required by Alaska law.

18. **Welcome Funds Inc.** recommends that you review the viatical/life settlement contract and consult with your financial and/or legal advisor prior to signing it.

I/We acknowledge that I/we have read and understand the disclosures above (1-18).

Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if not Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if not Insured)	Printed Name	Date
Signature of **Authorized Representative of Welcome Funds Inc.**	Printed Name	Date

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

Life Insurance Company _____

Policy Number _____

Printed Name of All Policy Owner(s) _____

Printed Name of Insured(s) _____

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, telephonic or other request for information or documents required by WELCOME FUNDS INC and/or its authorized representatives pertaining to the above-referenced life insurance policy that I/we own.

I/we understand and specifically authorize the release of information by this form to include any and all LIFE INSURANCE POLICY OR CERTIFICATE information, including but not limited to: *applications for insurance, forms, riders, illustrations, conversions, current values, verification of coverage, contestable and suicide status, lapse or reinstatement application and history and amendments concerning the policy or certificate, confirmation and status of change in ownership designations and any other general information about my coverage.*

WELCOME FUNDS INC makes it hereby known that the policy owner has the right to withdraw consent to this Release of Life Insurance Policy Information at any time, pursuant to applicable law. I/we understand that WELCOME FUNDS INC will keep all information disclosed hereunder confidential and will only use the information provided for the purpose of evaluating my life insurance coverage, determining my eligibility for sale of my life insurance policy and facilitating the potential sale of my life insurance policy. Furthermore, I/we understand that WELCOME FUNDS INC will not release any information to any person or organization except as may be otherwise lawfully required or as I/we may further authorize.

I/we certify that I/we am/are executing and delivering this Authorization freely and unilaterally/collectively as of the date written below. I/we further certify that I/we have a full understanding of the Authorization's contents and I/we will retain a completed copy for future reference. I/we specifically authorize and request that this Authorization for the Release of Life Insurance Policy Information shall remain valid until the death of the Insured or until the case is declined by WELCOME FUNDS INC, 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 and that a photocopy or facsimile of this document is as valid as an original. This document may also be signed in counterparts.

Authorized By:

Signature of **Policy Owner #1** _____ Printed Name _____ Date _____

Signature of **Policy Owner #2** (if any) _____ Printed Name _____ Date _____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I further 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 **Welcome Funds Inc** including a) any of its affiliates, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, buyers of life insurance policies, life expectancy providers, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (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, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), 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 a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted 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 Authorized 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"); 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 or other privacy laws and 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 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.

_____

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

Authorized by:

_____ _____ _____
Signature of **Individual** (Primary Insured) Printed Name Date

_____ _____ _____
Signature of **Legal Representative** of Primary Insured (if any) Printed Name Date

Description of Legal Representative's **Authority** (if any): _____
(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
FAX: 561.862.0242
WWW.WELCOMEFUNDS.COM

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I further 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 **Welcome Funds Inc** including a) any of its affiliates, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, buyers of life insurance policies, life expectancy providers, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (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, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), 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 a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted 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 Authorized 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"); 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 or other privacy laws and 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 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.

_____

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

Authorized by:

_____ _____ _____
Signature of **Individual** (Second Insured) Printed Name Date

_____ _____ _____
Signature of **Legal Representative** of Second Insured (if any) Printed Name Date

Description of Legal Representative's **Authority** (if any): _____
(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)

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BROKER AUTHORIZATION & SERVICES AGREEMENT

In consideration of the services provided, as described below, I/We agree to the following as part of this Broker Authorization & Services Agreement ("Agreement"):

1. **Welcome Funds Inc.** is authorized to serve as my/our viatical/life settlement broker and shall act in my/our best interests regarding and/or related to the sale of the following existing life insurance policy(ies):

1st Policy No. _____ issued by _____. 2nd Policy No. _____ issued by _____.
Name of Insurance Carrier (if applicable) **Name of Insurance Carrier**

1. In over to avoid any confusion in the marketplace, this Agreement shall nullify and supersede any other broker authorizations if any, that I/we have signed previously regarding and/or related to the sale of the polices referenced above.

2. **Welcome Funds Inc.** shall provide the following services, which includes but is not limited to:
   a. Pre-Qualification Policy Review.
   b. Evaluation Form Assessment.
   c. Medical Record Retrieval and Confirmations.
   d. Obtain Independent Third Party Life Expectancy Reports.
   e. Submit to Multiple Authorized and/or Licensed Providers (Buyers).
   f. Secure Conditional Offers.
   g. Execute Best Execution Negotiation.
   h. Policy and Insurance Verifications.
   i. Closing Services Including Assistance with Contingency Requirements.

3. **Welcome Funds Inc.** shall act as my/our viatical/life settlement broker beginning on the date of execution of this Agreement and continuing for one hundred eighty (180) days after the final offer is obtained/acquired regarding and/or related to the sale of the polices referenced above.

4. I/We grant **Welcome Funds Inc.** the authority, for the period of time described above, to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers, as determined by **Welcome Funds Inc.** pursuant to its typical methods and practices, regarding and/or related to the sale of the polices referenced above.

5. I/we recognize the proprietary nature of such appropriate, conditional offers as evaluated, underwritten, solicited, generated and secured by **Welcome Funds Inc.** for the period of time as described above and pursuant to this Agreement.

6. I/We agree that **Welcome Funds Inc.'s** compensation for the services described above is contingent upon the completed sale of my/our life insurance policy(ies). All compensation shall be paid by the provider (buyer) and/or the escrow company from the gross offer negotiated by **Welcome Funds Inc.** after the applicable rescission period has expired. Such compensation shall be calculated per applicable law.

Agreed to & Accepted by:

Signature of **Policy Owner #1**	Printed Name	Date
Signature of **Policy Owner #2**	Printed Name	Date
Signature of **Authorized Representative of Welcome Funds Inc.**	Printed Name	Date

APPENDIX A: SELLING YOUR LIFE INSURANCE POLICY (page 1)

Today, it's possible for you to sell your life insurance policy to someone else (a viatical settlement provider) for an immediate cash payment. This financial arrangement, known as a viatical settlement, is best suited for people who are living with an immediate life-threatening illness and facing tough financial choices.

It may not always be in your best interest to sell your life insurance policy. Before you take action, you should be sure you understand:

a) what future benefits you may lose; and
b) what other options may be available.

Selling your life insurance policy is a complex financial arrangement. This guide will help you make an informed decision.

We recommend that you

1. evaluate your needs;
2. check all your options;
3. understand how the process works;
4. know your rights; and
5. check with the Alaska Division of Insurance.

Step 1. Evaluate Your Needs

Before you sell your policy and give up valuable insurance protection, think about whether your need for life insurance has changed since you bought the policy. If it hasn't, selling your policy may not be the right choice. If you sell your policy now, your beneficiaries will not be paid a benefit at your death. If you sell your policy now, remember premiums go up a lot as you grow older. You may not want to pay the higher cost to replace your coverage later.

Step 2. Check All of Your Options

You may be able to get the cash you need now without selling your policy.

Policy Cash Values - Contact your current life insurance agent or company to see if you have any cash value in your policy.

Ask if you can:

(1) borrow from the cash value and still keep the insurance in force;
(2) cancel the policy for its current cash value; or
(3) use the cash value as collateral to get a loan from a financial institution.

Your insurance company must tell you about your options if you ask.

Accelerated Death Benefits - Find out if your policy has an "accelerated death benefit." It may be your best option. Many life insurance policies do have an accelerated death benefit. With that benefit, policyholders who are terminally ill, affected with certain diseases, or permanently confined in a nursing home can access 50 percent or more of a policy's death benefit while still living. An accelerated death benefit could pay you a large part of your policy's death benefit and you could keep your policy.

A very important feature of the accelerated benefit is that when the policyholder dies, the beneficiaries get the remaining death benefit. This means that eventually 100 percent of the policy benefits will be paid out either to the insured or the beneficiary.

Other Considerations - Think about what it will mean if you do sell your policy. Check out the tax implications. Not all proceeds from a viatical settlement are tax-free.

Find out if creditors could claim any of the money you would get from a viatical settlement.

Find out if you will lose any public assistance benefits such as medicaid or other government benefits if you accept a cash settlement for your life insurance policy.

Comparison Shop - To learn the market value of your policy, it's a good idea to contact three to five viatical settlement providers. Or you could use a viatical settlement broker who would contact several viatical settlement providers for you. Your financial advisor can help you decide whether to work with a viatical settlement provider or through a viatical settlement broker.

Summary - Everyone's financial situation is different. A viatical settlement may or may not be the best approach for you. Check it out for yourself. We recommend that you ask an advisor who is qualified to review your finances to help you review your options.

Step 3. How the Process Works

If you decide to sell your life insurance policy to a viatical settlement provider, you will enter into a viatical settlement agreement with the provider. You, the seller, agree to accept a cash payment for your policy. The amount will be less than the face amount the policy would pay upon your death. (For example, you might agree to accept a $75,000 cash payment for a $100,000 policy).

The viatical settlement provider buying your policy:

a) becomes the new owner of your policy;
b) names the beneficiary;
c) collects the full death benefit when you die;
d) begins paying premiums on the policy; and
e) may sell your policy again.

There are four basic phases required to complete a viatical transaction.

Phase 1 - Qualifying to Sell Your Policy (Underwriting)

The viatical settlement provider will need information about you before making an offer. Usually, the viatical settlement provider will take some preliminary information from you over the phone and send you this paperwork to sign:

a) a medical release form so the viatical settlement provider can get and review your medical records; and
b) an authorization form to contact your insurance company to confirm benefit, premium, and ownership of your policy.

To avoid delays, it's important that you give complete and accurate information about your medical history. If you apply with more than one viatical settlement provider, each will contact your doctor for medical records and your insurance company for policy information.

Phase 2 - Calculating the Offer

The viatical settlement provider uses the information it gets in the underwriting phase to make an offer. To develop an offer, a viatical settlement provider takes into account various factors including:

a) estimated life expectancy and medical condition of the insured; generally, the shorter the life expectancy of the insured, the more the viatical settlement provider will offer for the policy;
b) the amount of life insurance coverage;
c) loans or advances, if any, previously taken against the policy;
d) amount of premiums necessary to keep the life insurance policy in force;
e) the rating of the issuing insurance company;
f) prevailing interest rates; and
g) payment restrictions.

Phase 3 - Closing the Agreement

If you accept an offer, a closing package is forwarded to you, the seller, for approval and signature. Closing documents typically include an offer letter, a viatical settlement contract, and the forms the insurance company needs to transfer ownership of the policy to the viatical settlement provider. The closing documents are then returned to the viatical settlement provider for its signature. The viatical settlement provider will put the cash payment owed to you in escrow, if required, and send the signed insurance change forms to the insurance company to record the change.

Phase 4 - Receiving the Payment

Once the insurance company notifies the viatical settlement provider that the changes on the life insurance policy have been recorded, the payment is released to you, the seller, usually the next business day.

Step 4. Know Your Rights

State laws

Alaska insurance laws provide important consumer protections including the following:

a) viatical settlement broker or viatical settlement provider arranging viatical settlements must be licensed with the Alaska Division of Insurance;
b) with few exceptions, the viatical settlement provider buying your policy must keep your identity and medical history confidential unless you give written consent to tell others;
c) to protect your proceeds, the viatical settlement provider buying your policy must put your money into an escrow account with an independent party during the transfer process;
d) you have the right to change your mind about the settlement within 15 days AFTER you receive the money, provided you return all the money;
e) the new owners of your policy are limited in how often they may contact you about your health status.

Federal Tax Laws

Two groups of people might receive benefits from a viatical settlement without owing federal income tax:

a) persons who have been diagnosed with a terminal illness and a life expectancy of 24 months or less; and
b) certain chronically ill individuals.

Before entering into a viatical settlement, consult your own financial advisor or tax attorney about the federal tax consequences.

Before entering into a viatical settlement, consult your own financial advisor or tax attorney about the federal tax consequences.

Avoiding Consumer Fraud

If you're in good health and someone asks you to sell your life insurance policy, proceed with caution. Refer to the section on selling your life insurance policy.

If you've been contacted by someone who wants you to buy a policy and then sell it immediately, you should contact the Alaska Division of Insurance. You may be a target for fraud.

If you're asked to buy a life insurance policy for the sole purpose of selling it, you may be participating in fraud. Contact the Alaska Division of Insurance to report the request and to obtain information.

If you're asked to invest in a viatical settlement, we recommend that you contact the Alaska Division of Insurance to learn more about the issues and risks that might be involved in such an investment.

Step 5. Check with the Alaska Division of Insurance

State Licensing

For a complete list of authorized viatical settlement providers, viatical settlement brokers, and viatical settlement representatives, call the Alaska Division of Insurance.

Seller Checklist

Before you sell your policy be sure you know the answers to these questions.

Evaluating Your Needs

a) Do you still need life insurance?
b) Do you have dependents who might rely on your life insurance benefits should anything happen to you?
c) If you don't need life insurance protection now, what are the chances you'll need it in the future?

Current Policy Benefits

a) Can you borrow from the cash value?
b) Can you cancel the policy for its current cash value?
c) Can you use the cash value as collateral to get a loan from a financial institution?
d) Do you have art accelerated death benefit feature?

Taxes and Other Financial Considerations

a) Is the money you get from selling the policy taxable?
b) Will the money you get from selling the policy affect your eligibility for government benefits?
c) Do you need the advice of a tax or estate-planning specialist before you decide to sell your policy?
d) If you sell your policy, can any of your creditors claim the money?

Understanding the Process

a) If you sell your policy, who will be the legal owner?
b) Is the viatical settlement provider buying your policy licensed?
c) If you sell your policy, how will the value you get be calculated?
d) What interest rate will be used?
e) If you sell your policy but then change your mind, can you get your money back?

f) Will investors have specific information about you, your family, or your health status?
g) How are fees or commissions paid to the viatical settlement broker or viatical settlement provider?

Protections in Your State

Contact the Alaska Division of Insurance to find out about the laws governing viatical settlements.