Nevada
Life Insurance
Evaluation Package

DANIEL A. OHMAN
6001 BROKEN SOUND PKWY
SUITE 320
BOCA RATON, FL 33487

NV INSURANCE PRODUCER
LICENSE #: 211719

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
FAX: 561.862.0242

LETTER FROM DANIEL A. OHMAN

Dear Policy Owner/Insured:

Thank you for choosing me to help you determine and identify the merits and value of selling your policy. I understand that the process can be intimidating and overwhelming and it is my job to not only maximize the sales value of your policy(ies) in the secondary market, but also to provide a seamless, transparent and fully informed experience. Please complete my Evaluation Request for Sale of Existing Life Insurance and sign the appropriate pages.

As your designated broker who represents your best interests and follows your instructions, I incur the necessary, required and related costs to facilitate the potential sale of your policy related to the following services:

- Evaluation Form assessment.
- Medical underwriting and insurance verifications.
- Obtaining and forwarding independent third party life expectancy reports.
- Submission to multiple authorized and/or registered buyers of life insurance policies.
- Best execution negotiation to maximize fair market value of the sale of your policy.
- Closing services including contract review and assistance with contingency requirements of buyers of life insurance policies.

Please read the Notice of Disclosure and the Broker Authorization and Services Agreement carefully and sign accordingly. These pages represent the first step in explaining your rights and obligations associated with the process. With that said, you are under no obligation to accept any contingent offers I secure on your behalf. Furthermore, I have attached a brief brochure issued by the National Association of Insurance Commissioners (NAIC), a non-profit organization of insurance regulators from all 50 states, to provide an unbiased, independent description of selling policies in the secondary market. Please read the NAIC material as well.

Please be advised that the personal information acquired shall only be shared with individuals and entities with an identifiable need to help determine the market value of your policy, including but not limited to life expectancy underwriters and potential buyers of your policy. All parties involved in the analysis, evaluation, underwriting and contingent pricing for transactions are required to maintain strict privacy and confidentiality safeguards pursuant to applicable state and federal regulations.

Once again thank you for allowing me 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,

Daniel A. Ohman
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REQUIRED REFERRING ADVISOR/BROKER INFORMATION & ATTESTATION (IF APPLICABLE)

This page is to be completed & signed by Referring Advisors/Brokers ONLY.
If there is no Referring Advisor/Broker, then please skip this page.

As a necessary requirement to help facilitate & to receive compensation related to this potential transaction, please attach ALL applicable licenses described below (certain states may not require or issue a broker license).

Life Insurance Policy # 1

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 2 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 3 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 4 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Referring Advisor/Broker Information

Name: _____

Relevant Valid State Producer License # & Expiration: _____

Relevant Valid State Broker License # & Expiration (if applicable): _____

Referring Advisor/Broker Signature

I hereby attest that the above Referring Advisor/Broker Information is true and accurate and that I am, during the potential or actual sale of the existing life insurance policy(ies) described above a) authorized to represent the above Policy Owner(s) and to accept offers on his/their behalf; b) the primary and often only direct contact with such Policy Owner(s) to determine suitability and the value and merit of selling the existing life insurance policy(ies) described above; c) representing the Policy Owner(s) in a fiduciary capacity and always in the best interest of the Policy Owner(s); and d) warranting that I have reviewed the disclosure statements contained in the "Notice of Disclosure" herein with such Policy Owner(s).

_____
Signature of Referring Advisor/Broker Date

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ADDITIONAL DOCUMENT CHECKLIST

Please include the following documents, if available, with your Evaluation Request to significantly decrease the time necessary to facilitate the potential sale of your policy. If you cannot provide the items below, then Daniel A. Ohman and his designated representatives will attempt to obtain items A & B with the authority granted from the signed authorizations contained herein. Items C through H must be obtained through your own efforts.

☐ A. Current In Force Illustrations for Each Policy (please confirm desired/required illustrations with Daniel A. Ohman).

☐ B. Complete Medical History Dating Back at least Two (2) Years Prior to the Issuance of the Policy for Each Insured.

☐ C. Photocopy of Two Forms of Identification (ie. Drivers License, SS Card, Passport etc...) for Each Insured & Policy Owner.

☐ D. Photocopy of Applicable Insurance Policy/Policies (including applications for insurance).

☐ E. Photocopy of Trust or Corporate Formation Documents (if applicable).

☐ F. Photocopy of Divorce Decree of Insured & Policy Owner (if applicable).

☐ G. Photocopy of Bankruptcy Discharge of Insured & Policy Owner (if applicable).

☐ H. Photocopy of All Premium Finance Documents (if applicable).

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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

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.

The information provided below shall be used to evaluate, underwrite and generate conditional offers for the sale of your life insurance policy.

PRIMARY INSURED'S PERSONAL INFORMATION

PRIMARY INSURED NAME (AS LISTED WITH LIFE INSURANCE CARRIER) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER**

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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**

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

SECONDARY INSURED'S PERSONAL INFORMATION (IF APPLICABLE – SURVIVORSHIP ONLY)

SECONDARY INSURED NAME (AS LISTED WITH LIFE INSURANCE CARRIER) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER**

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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**

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 if there is additional medical information, then please attach a separate sheet with complete details.

LIFE INSURANCE POLICY INFORMATION

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

FACE AMOUNT | **TOTAL POLICY LOAN AMOUNT** | **CASH SURRENDER VALUE**

☐ 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

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

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

EXACT NAME OF POLICY OWNER (INDIVIDUAL / CORP. / TRUST - AS LISTED WITH LIFE INSURANCE CARRIER) | **SOCIAL SECURITY OR TAX ID NUMBER**

POLICY OWNER ADDRESS (ADDRESS / STATE OF DOMICILE OF INDIVIDUAL / CORP. / TRUST) | **TELEPHONE NUMBER**

CITY | **STATE** | **ZIP CODE**

EXACT NAME OF CORPORATE OFFICER(S) / TRUSTEE(S) (IF CORPORATE / TRUST OWNED POLICY) | **DATE OF INCORPORATION / TRUST**

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

IF THERE ARE MULTIPLE 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 POLICY OWNER EVER DECLARED BANKRUPTCY? | **IF SO, HAS IT BEEN DISCHARGED?** | **WHEN WAS IT DISCHARGED?**

For multiple policies, please photocopy this page, complete the above information and sign new insurance authorizations for each policy.

FINANCIAL INFORMATION (REQUIRED FOR SUITABILITY REVIEW)

All Policy Owner(s) and Insured(s) please sign at the bottom of the page, regardless of whether you complete all of the financial information below.

Please be advised that any Policy Owner(s) and/or Insured(s) who declines to provide full and complete financial data acknowledges and accepts responsibility that such lack of data will impede **Daniel A. Ohman's** ability to provide recommendations it deems suitable, based on personal and specific financial needs, conditions and situations.

☐ **Check here if you choose NOT to complete some or all of the requested financial information below (and sign below).**

I. INVESTMENT PROFILE (PLEASE USE COMBINED FIGURES FOR JOINT ACCOUNTS):

INVESTMENT OBJECTIVES: *(check all that apply)*
☐ Capital Preservation ☐ Income ☐ Capital Appreciation/Growth ☐ Speculation

POLICY OWNER'S TAX BRACKET:
☐ 10% ☐ 15% ☐ 25% ☐ 28% ☐ 33% ☐ 35%

POLICY OWNER'S NET WORTH:
☐ $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 and up

ESTIMATED INSURABLE CAPACITY FOR INSURED(S): $_____

TOTAL AMOUNT OF IN-FORCE LIFE INSURANCE COVERING INSURED(S): $_____

II. PLEASE DESCRIBE REASONS FOR CONSIDERING THE SALE OF POLICY(IES), CHECK ALL THAT APPLY:

☐ No longer require or want to pay for the life coverage
☐ Health & living expenses are a financial burden
☐ Interested in learning market value of policy
☐ Planning to lapse, cancel, or surrender the policy
☐ Considering a 1035 Exchange or replacement policy
☐ Cash liquidity preferred due to current financial situation
☐ Other or provide further details: _____

III. PLEASE CERTIFY THE CURRENT ACCREDITED INVESTOR STATUS OF THE POLICY OWNER:

THE POLICY OWNER IS CONSIDERED AN ACCREDITED INVESTOR: ☐ YES ☐ NO

(Refer to the definitions below to answer the above question and if "yes," then please check the appropriate description)

INDIVIDUALS:

_____ 1. An individual that has a net worth or joint net worth, with the individual's spouse, in excess of $1,000,000. "Net worth" for these purposes is defined as the value of total assets at fair market value, including but not limited to non-primary residence home (the value of the primary residence, as of July, 2010, is excluded), home furnishings and automobiles, less total liabilities; or

_____ 2. An individual that (i) had income (exclusive of any income attributable to the individual's spouse) of more than $200,000 for each of the past two years or joint income with the individual's spouse in excess of $300,000 in each of those years, and (ii) reasonably expects to reach the same individual income level, or the same joint income level, as the case may be, in the current year; or

ENTITIES:

_____ 3. A corporation, partnership, limited liability company, Massachusetts or similar business trust or tax-exempt organization as defined in Section 501(c)(3) of the Code, that (i) has total assets in excess of $5,000,000, and (ii) was not formed for the specific purpose of investing in the life insurance policy and then selling it; or

_____ 4. A revocable trust which may be amended or revoked at any time by the grantors thereof, and of which all of the grantors are accredited investors under either (1) or (2) above; or

_____ 5. A trust (i) that has total assets in excess of $5,000,000, (ii) that was not formed for the specific purpose of acquiring the life insurance policy and then selling it, and (iii) whereby the investment decisions are directed by a person who has such knowledge and experience in business and financial matters and who can evaluate the merits and risks of its investments; or

_____ 6. A trust for which a bank or savings and loan association is acting as fiduciary in directing investment decisions; or

_____ 7. An entity whose equity owners are each "accredited investors" i.e., persons meeting the requirements set forth in either of (1) or (2) above.

Verified and Confirmed By:

Signature	Printed Name	Date
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

PERSONAL ACKNOWLEDGEMENTS

I. Do you have a referring advisor/broker authorized, on your behalf, to a) represent your interests regarding this Evaluation Request & potential transaction; & b) to accept offers, if any, for the sale of your existing life insurance policy?

☐ Yes ☐ No

If Yes, then please provide the name(s) of such advisor(s)/broker(s) below:

Name of **Referring Advisor /Broker #1** | Name of **Referring Advisor/Broker #2** (if applicable)

II. Have you signed a Power of Attorney (POA) granting a legal representative to act on your behalf or do you have a Guardian ad Litem or similar legal representative acting on your behalf regarding this Evaluation Request & Potential Transaction?

Primary Insured: ☐ Yes ☐ No | Policy Owner #1: (if not Insured): ☐ Yes ☐ No

Secondary Insured (if applicable): ☐ Yes ☐ No | Policy Owner #2 (if applicable): ☐ Yes ☐ No

If Yes, then please 1) attach the applicable legal documents to this Evaluation Request; 2) have the legal representative of the insured sign the "Authorization for Disclosure of Protected Health Information" forms for the primary and secondary insured as applicable; 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)

III. How did you learn about the option to sell your insurance policy?

☐ Through my/our own knowledge and/or research and asked to receive this Evaluation Request.

☐ Through my/our referring advisor/broker.

IV. Was this insurance policy premium financed?

☐ Yes ☐ No

If yes, then please 1) attach all finance documents, including contracts, trusts and/or corporate documents etc…in order to evaluate and determine the validity and legality of this potential transaction for insurable interest; 2) provide the name of the financing company: _____.

Name of **Financing Company** (if applicable)

I/We represent that the information contained in this Evaluation Request for Sale of Existing Life Insurance is correct and accurate and acknowledge that **Daniel A. Ohman** and his authorized representatives may rely on such information, including but not limited to the Personal Acknowledgements above. I/we will immediately notify **Daniel A. Ohman** and/or his authorized representatives of any changes.

I/We give my/our consent to **Daniel A. Ohman**, and his authorized representatives to release and/or transmit electronically all financial and insurance 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 facilitate the sale of my/our life insurance policy.

I/We further acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my contract for the sale of my existing life insurance policy if my/our life insurance 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 life insurance policy(ies).

Acknowledged By:

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

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NOTICE OF DISCLOSURE (PAGE 1 OF 2)

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. **Daniel A. Ohman** and your referring advisor/broker, if any, represents exclusively you & not the insurer or provider or any other person and owes you a fiduciary duty, including to act according to your instructions and in your best interest notwithstanding the manner in which **Daniel A. Ohman** and your referring advisor/broker, if any, is compensated.

2. Some or all of the proceeds of your viatical/life settlement may be taxable under federal income tax or state franchise and income tax laws. **Daniel A. Ohman** is not a tax advisor and recommends that you consult your own professional tax advisor regarding this transaction.

3. Receipt of the proceeds of the viatical/life settlement may adversely affect your eligibility for Medicaid or other government benefits or entitlements. Advice should be obtained from the appropriate government agencies.

4. Viatical/life settlement proceeds may be subject to the claims of creditors.

5. There are possible alternatives to viatical/life settlement contracts. 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 the viatical/life settlement within the rescission period, as provided by Nevada law (NRS 688C.300). "Rescission period" is defined as the shorter of sixty (60) days after the date in which a viatical/life settlement is signed by all parties or thirty (30) days after you receive the proceeds from the viatical/life settlement. If the insured dies during the rescission period, then the settlement contract is deemed rescinded and all proceeds must be repaid to the provider within sixty (60) days after the death of the insured. Rescission, if exercised by you, is effective only if you give notice of the rescission to the provider or **Daniel A. Ohman** and you repay to the provider all proceeds and any premiums, loans and loan interest paid on account of the viatical/life settlement or on behalf of the provider of viatical/life settlements within the rescission period.

7. Funds will be sent to you within three (3) business days after the viatical/life settlement provider has received the insurer's or group administrator's written acknowledgement that ownership of or interest in the policy has been transferred and that the beneficiary has been designated. **Daniel A. Ohman** and your referring advisor/broker, 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 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 financial advisor.

[Additional disclosures are on the following page]

NOTICE OF DISCLOSURE (PAGE 2 OF 2)

9. Total compensation payable to **Daniel A. Ohman** and your referring advisor/broker, 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. Actual compensation shall be disclosed no later than the date of execution of the viatical/life settlement contract.

10. All medical, financial or personal information solicited or obtained by a provider or **Daniel A. Ohman** about the insured, including the insured's identity or the identity of family members, a spouse or other relationship may be disclosed as necessary to effect the viatical/life settlement between you and the provider. If you are asked to provide this information, you will be asked to consent to this disclosure. Failure to consent may affect your ability to viaticate your policy. 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. Following the execution of the viatical/life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number. The viatical/life settlement contract will define the contact limitations in detail.

12. **Daniel A. Ohman** 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 **Daniel A. Ohman** 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).

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 **Daniel A. Ohman**	Printed Name	Date

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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 **Daniel A. Ohman** and/or his 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.*

Daniel A. Ohman 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 **Daniel A. Ohman** and his authorized representatives 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 **Daniel A. Ohman** and his authorized representatives 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 **Daniel A. Ohman**, 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 **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 _____

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (PRIMARY 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 **Daniel A. Ohman** including any of his agents, 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, facilitate, underwrite and solicit bids for 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 his 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 the Authorized Recipient 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. 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.

_____

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)

DANIEL A. OHMAN
6001 BROKEN SOUND PKWY
SUITE 320
BOCA RATON, FL 33487

NV INSURANCE PRODUCER
LICENSE #: 211719

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
FAX: 561.862.0242

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION (SECONDARY 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:

7. **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.
8. **Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Daniel A. Ohman** including any of his agents, 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, facilitate, underwrite and solicit bids for 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 his 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.
9. **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 the Authorized Recipient 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. 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.
10. **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.
11. **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.
12. **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.

_____

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

Authorized by:

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

_____ _____ _____
Signature of **Legal Representative** of Secondary 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

Do you have a referring advisor/broker working with **Daniel A. Ohman** and his authorized representatives whereby such advisor/broker is authorized to a) represent your interests regarding this Evaluation Request & potential transaction; & b) accept offers, if any, on your behalf?

☐ Yes ☐ No If Yes, then please provide the name(s) of such advisor(s)/broker(s) below:

_____ _____
Name of **Referring Advisor /Broker #1** Name of **Referring Advisor/Broker #2** (if applicable)

Daniel A. Ohman represents the best interests of consumers and maximizes the sales value of their policy(ies) in the secondary market for life insurance. As your designated broker, **Daniel A. Ohman** incurs the necessary, required and related costs to facilitate the sale of your policy while he and his authorized representatives provide the following services including but not limited to:

- Evaluation Form assessment.
- Obtaining and forwarding independent third party life expectancy reports.
- Best execution negotiation to maximize fair market value of the sale of your policy.
- Medical underwriting & insurance verifications.
- Submission to multiple authorized and/or registered buyers of life insurance policies.
- Closing services including contract review & assistance with contingency requirements of buyers of life insurance policies.

In consideration of the services provided and related costs incurred as described above, I/We authorize **Daniel A. Ohman** and his authorized representatives to act as my/our broker and to evaluate, underwrite, solicit, generate and secure conditional offers beginning on the date of execution of this Agreement and continuing for 180 days after the final offer is obtained/acquired regarding and/or related to the purchase of the following life insurance policy(ies):

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

Furthermore, by signing this authorization and agreement, I/we am/are:

1. Granting to **Daniel A. Ohman** and his authorized representatives the authority, for the period of time described above, to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers as determined by **Daniel A. Ohman** pursuant to his typical business model, methods and practices, for the sale of my/our life insurance policy(ies) as stated above.
2. Recognizing the proprietary nature of such appropriate, conditional offers as evaluated, underwritten, solicited, generated and secured by **Daniel A. Ohman** and/or his authorized representatives for the period of time as described above and pursuant to this Broker Authorization & Services Agreement.
3. Agreeing to the total compensation, as described in this paragraph, payable to **Daniel A. Ohman** and your referring advisor/broker, if any. Such total compensation shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds from the sale of your life insurance policy are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the buyer of the policy reduced by the total compensation as described in this paragraph.
4. Aware that **Daniel A. Ohman** and his authorized representatives issue no guarantee that my/our life insurance policy will be sold, is under no obligation to purchase my/our policy or to ultimately find a buyer of my/our policy(ies) and is not responsible for any breach committed by a buyer if one is identified.

Agreed to & Accepted by:

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 **Daniel A. Ohman**	Printed Name	Date