

It's about
Choice



WELCOME
FUNDS

Life Settlements. Simplified.®



ARIZONA
STATE APPLICATION

1.877.227.4484

welcomefunds.com



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

State of Arizona

Life Settlement Broker License

ARIZONA INSURANCE LICENSE

License No: 1800011361

WELCOME FUNDS INC

4755 TECHNOLOGY WAY
SUITE 202
BOCA RATON FL 33431
NON-RESIDENT

As of August 12, 2021

LICENSE CLASS	FIRST ACTIVE DATE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY	LOA EFFECTIVE DATE
Insurance Producer	09/20/2013	10/01/2021	09/30/2025	Property	09/20/2013
				Life	09/20/2013
				Accident and Health or Sickness	09/20/2013
				Casualty	09/20/2013
Life Settlement Broker	10/16/2013	10/01/2021	09/30/2025	Personal Lines	09/20/2013
				Life Settlement Broker	10/16/2013

APPOINTMENT DATA IS NOT COLLECTED, TRACKED OR MAINTAINED IN ARIZONA.

Arizona Department of Insurance and Financial Institutions
100 N 15th Ave, Suite 261
Phoenix, AZ 85007-2630

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:

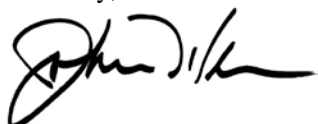
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the 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



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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
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PRIMARY ATTENDING PHYSICIAN	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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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 APPLICABLE 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
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PRIMARY ATTENDING PHYSICIAN	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
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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 APPLICABLE 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
			<input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY LOAN AMOUNT (IF ANY)	ACCUMULATED/CASH VALUE (IF ANY)	CASH SURRENDER VALUE (IF ANY)	CASH VALUE USED TO PAY PREMIUMS?
<input type="checkbox"/> Individual	<input type="checkbox"/> Joint Survivorship	<input type="checkbox"/> Group	<input type="checkbox"/> 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			
<input type="checkbox"/> Term	<input type="checkbox"/> WL	<input type="checkbox"/> UL	<input type="checkbox"/> Other: _____
CLASSIFICATION OF POLICY (PLEASE CHECK ONE)			
<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> 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		
<input type="checkbox"/> Family Member	<input type="checkbox"/> Spouse	<input type="checkbox"/> Business Partner
<input type="checkbox"/> Policy Owner is Insured	<input type="checkbox"/> Other: _____	
IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK APPLICABLE RELATIONSHIP TO INSURED		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced – Date: _____	
IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK MARITAL STATUS		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
<input type="checkbox"/> 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:

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

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 ACKNOWLEDGEMENTS

- 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 4755 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



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ARIZONA PRIVACY ACKNOWLEDGEMENT & AUTHORIZATION

The following section, in part, contained in Arizona Law, addresses the way the insured's personally identifiable information, including without limitation, his or her financial, medical and insurance related information, is permitted to be disclosed. With the insured's and owner's required signatures, the insured and owner are acknowledging the law as indicated below and authorizing their consent to such disclosure.

Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance producer or any other person with actual knowledge of an insured's identity shall not disclose the identity of an insured or any information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure is one of the following:

- (1) necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;
- (2) necessary to effectuate the sale of life settlement contracts or interests in life settlement contracts as investments if the sale is conducted pursuant to applicable state and federal securities laws and the owner and the insured have both provided prior written consent to the disclosure;
- (3) provided in response to an investigation or examination by the director or any other state or federal agency;
- (4) a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with all applicable laws regarding the confidentiality of medical information;
- (5) necessary to allow the provider or broker or the provider's or broker's authorized representatives to make contacts for the purpose of determining health status. For the purposes of this paragraph, authorized representative does not include any person who has or may have any financial interest in the settlement contract other than a provider or licensed broker. Authorized representatives shall agree in writing to adhere to all applicable confidentiality and privacy laws; or
- (6) required to purchase stop loss coverage.

In addition to the acknowledgement and authorization above, with the signature below, each undersigned is allowing his or her personally identifiable information, including without limitation, his or her financial, medical and insurance related information, to be transmitted electronically, via e-mail or through a password protected and secure website, to the appropriate parties, as permitted by Arizona law, who have an identifiable need to facilitate the sale of the life insurance policy or policies.

Acknowledged & 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

FORM P-LSDO: LIFE SETTLEMENT PROVIDER/BROKER DISCLOSURES TO OWNER

PROVIDER/BROKER INFORMATION			
Provider/Broker Name:			
Business Address:			
City		State	ZIP Code
Phone:	Provider/Broker Representative (if provider/broker is not an individual):		
LIFE INSURANCE POLICY OWNER/SELLER INFORMATION			
First Name	Middle Name	Last Name	Jr/Sr/III/etc.

Arizona law allows you to sell your life insurance policy to a third party for an amount that is less than the full death benefit. The buyer becomes the new owner and the beneficiary of the life insurance policy, pays all future premiums and collects the entire death benefit when you die. This is called a life settlement contract.

Arizona Revised Statutes ("ARS") § 20-3204, subsections A and B, require that a life settlement provider or life settlement broker provide you with the following information in writing before you apply for or enter into a life settlement contract:

IMPORTANT: READ THIS DISCLOSURE FORM BEFORE SIGNING ANY LIFE SETTLEMENT CONTRACT

Before you submit an application for a life settlement, you should know:

1. There are possible alternatives to life settlements, including accelerated benefits options that your life insurer may offer or policy loans.
2. Some or all of the proceeds of a life settlement may be taxable. You should seek assistance from a professional tax adviser.
3. The proceeds from a life settlement could be subject to the claims of creditors.
4. Receiving proceeds from a life settlement contract may adversely affect your eligibility for public assistance or other government benefits or entitlements. You should obtain advice from the appropriate agencies.
5. Entering into a life settlement contract may cause you to forfeit other rights or benefits including conversion rights and waiver of premium benefits that you may have under the policy or certificate of a group policy. You should seek assistance from a professional financial adviser.
6. You can rescind the life settlement contract within **fifteen (15) days** after the date that all parties execute the life settlement contract and you have received all required disclosures (the "rescission period"). To rescind the life settlement contract, you must notify the provider in writing, and you must repay all proceeds and any premiums, loans and loan interest paid on account of the provider during the rescission period. If the insured dies during the rescission period, the life settlement contract shall be deemed rescinded once you or your estate repay all proceeds and any premiums, loans and loan interest to the provider.

7. Before the provider can pay you the proceeds from the life settlement contract, the provider needs to be notified by the life insurer or group administrator that the ownership of the policy or the interest in the certificate of insurance has been transferred, and that the beneficiary has been designated according to the terms of the life settlement contract. The provider is required to pay you the proceeds from the life settlement contract within three business days after the provider has received the insurer or group administrator's notification.
8. The provider should tell you the date by which the monies will be available to you and the transmitter of the monies.
9. The provider or the broker or its authorized representative may periodically contact the insured to determine the insured's health status or to verify the insured's address. **This contact is limited to once every three months if the insured has a life expectancy of more than one year, and is limited to once per month if the insured has a life expectancy of one year or less.**
10. Attached to this disclosure document is Form P-LSA: Life Settlement Affiliations, which provides information about the broker, and notifies you of affiliations or contractual relations between the provider and the broker, and any affiliation between the provider and the issuer of the policy to be settled.
11. A broker represents you exclusively and not the insurer or the provider or any other person. The broker owes a fiduciary duty to you, including a duty to act according to your instructions and in your best interest.

All medical, financial or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract between you and the provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides monies for the purchase. You may be asked to renew your permission to share information every two years.

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a class 1 misdemeanor and may be subject to fines and confinement in jail.

Signature required by ARS § 20-3204(A). By signing this form, you acknowledge that you read and understand the information contained on this disclosure document. If you need legal advice, you should consult an attorney.

► Owner/Seller Signature: _____ Date _____

► Provider/Broker Signature: _____ Date _____

Life Settlement Provider/Broker Disclosures to Owner
FORM P-LSA: LIFE SETTLEMENT AFFILIATIONS

BROKER INFORMATION			
Name of Life Settlement Broker ("Broker")		AZ Insurance License No.	
Business Address	City	State	ZIP Code
PROVIDER INFORMATION			
Name of Life Settlement Provider ("Provider")		AZ Insurance License No.	
Provider's Representative <i>(if the Provider is not an individual)</i>			
BROKER AND PROVIDER AFFILIATIONS OR CONTRACTUAL RELATIONS			
Description of affiliations or contractual relations between Broker and Provider			

PROVIDER AND ISSUER AFFILIATION	
Name of Life Insurer ("Issuer")	NAIC Number
Description of affiliation, if any, between Provider and Issuer	

► Provider/Broker Signature: _____ 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 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:

- 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.
- 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.
- 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.
- Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
- 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.
- 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)

Defining the Terms

A **life settlement** is the sale of a life insurance policy to another person or company in return for a cash payment of less than the full amount of the death benefit.

A **life settlement provider** is the person or company that becomes the new policy owner in return for a payment made to the seller. The life settlement provider becomes the policy owner, must pay any premiums that are due, and eventually collects the full amount of the death benefit from the insurance company.

A **life settlement broker** is the person or company who represents the seller of the policy and can comparison shop for life settlement offers. The buyer pays the broker a commission if the sale is completed.

Additional Questions to Consider

- Do I still need life insurance protection?
- Will I qualify for a new life insurance policy in the future?
- If I sell my policy, how will they decide how much cash I get?
- If I sell my policy, will there be any costs I have to pay?
- If I sell my policy, will the money be put into an escrow account? If so, who will the escrow agent be? Does state law require the agent to be licensed?
- Is my policy an employer or other group policy? If so, do I need their permission to sell it?
- If I sell my policy, who will be the legal owner?
- Is the viatical settlement provider I plan to sell to allowed to do business in my state?
- After I sell my policy, can the buyer resell it?



Consumer Alert

- **If you're asked to invest in or buy a life settlement, contact your state insurance department to learn more about the issues and risks.**
- **If you don't have a life-threatening illness and you're interested in selling your life insurance policy, contact your state insurance department for more information.**
- **If you've been contacted by someone who wants you to buy a policy and then sell it immediately, contact your state insurance department. This activity may be considered fraudulent and the parties may be prosecuted by the appropriate authorities.**

Selling Your Life Insurance Policy: Understanding Life Settlements

Check with Your State



Your state insurance department may regulate the purchase of life settlements. Contact them for a copy of those regulations.



This publication was issued in joint cooperation with the:
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, Mo. 64108
(816)842-3600
<http://www.naic.org>

Understanding Life Settlements

A **life settlement** is the sale of a life insurance policy to a third party. The owner of a life insurance policy sells it for a cash payment that is less than the full amount of the death benefit. The buyer becomes the new owner and/or beneficiary of the life insurance policy, pays all future premiums and collects the full amount of the death benefit when the insured dies.

People decide to sell their life insurance policies for many reasons. When an individual with a terminal or chronic illness sells his or her life insurance policy, that is known as a **viatical settlement**. When an individual who does not have a terminal or chronic illness sells a policy for other reasons, including changed needs of dependents, wanting to reduce premiums, and cash for meeting expenses, that is known as a **life settlement**.

A life settlement may or may not be the right choice for you. Your state insurance department, along with the National Association of Insurance Commissioners, is concerned that many consumers may not fully understand life settlements. Please continue reading before making any decisions.

Get All of the Facts

Before you enter into any life settlement transaction, you should:

- Contact your life insurer to learn about all of your possible options under your policy.
- Contact a life settlement broker or life settlement provider for information about life settlements.
- Consult with your own financial advisor who knows your personal financial needs. Be sure to ask about tax and other financial consequences if you sell your policy.
- Contact your state insurance department for information about current laws that may protect you.



Consider All Your Options

- Find out if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries without having to sell it to a third party. You may also be able to use the cash value as security for a loan from a financial institution.
- Review other sources of cash that may meet your financial needs at a lower cost than a life settlement.



Other Considerations

- Contact a professional tax advisor. Find out the tax implications. **Proceeds are only tax-free under certain circumstances.**
- Know that your creditors could claim the proceeds.
- Find out if you'll lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- Know that you must provide certain medical and personal information to third parties who will be paid the proceeds from your policy upon your death. These third parties may sell your policy and pass along your medical and personal information to other individuals.

Consumer Tips

- Understand how the process works and when the different phases will happen.
- Decide whether to sell your policy directly to a life settlement provider or go through a life settlement broker who will do the comparison shopping for you.
- If you don't use a life settlement broker, comparison shop on your own.
- You don't have to accept any life settlement offer.
- Check all application forms for accuracy, especially information about your medical history.
- You must be truthful in your answers to application questions.
- Make sure the life settlement provider agrees to put your settlement proceeds in escrow with an independent party or financial institution to make sure your funds are safe during the transfer.
- Find out if you have the right to change your mind about the life settlement offer after you get the proceeds. In many states, you have the right to change your mind for a certain period of time. If you have that right, you'll have to return the money you were paid and premiums the buyer paid.
- Understand whether buyers may learn your identity when they buy your policy, and whether they will know certain medical and personal information about you, such as your address and life expectancy.