

It's about  
*Choice*



CALIFORNIA REPUBLIC



WELCOME  
FUNDS

*Life Settlements. Simplified.®*



**CALIFORNIA  
STATE APPLICATION**

# State of California

## *Life Settlements Broker License*

### California Department of Insurance

WELCOME FUNDS, INC

License # 0G50077

DBA: WELCOME FUNDS INC., A VIATICAL SETTLEMENT BROKERAGE  
DBA: WFI LIFE INSURANCE SERVICES

Pursuant to the requirements of the State of California Insurance Code,  
WELCOME FUNDS, INC is authorized to act in the following capacity:

License

Non-Resident Insurance Producer

Qualifications

Accident and Health Agent

Brokering Life Settlement

Life-Only Agent

Effective Date

03/09/2009

03/09/2009

07/01/2010

03/09/2009

Expiration Date

03/31/2019

Business Address: 6001 Broken Sound Parkway, Suite 320, Boca Raton, Florida 33487

  
Dave Jones, Insurance Commissioner





WELCOME FUNDS INC.  
d/b/a WFI LIFE INSURANCE SERVICES  
6001 BROKEN SOUND PKWY  
SUITE 320  
BOCA RATON, FL 33487

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

## EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

***Fraud Warning: Any person who knowingly presents false information in an application for insurance or a 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				
<input type="checkbox"/> Family Member <input type="checkbox"/> Spouse <input type="checkbox"/> Business Partner <input type="checkbox"/> Other: _____				
PLEASE CHECK APPLICABLE 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
<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			
<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 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				
<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 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.**

## ADDITIONAL INFORMATION

### I. 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  
☐ Other or provide further details: \_\_\_\_\_
- ☐ Planning to lapse, cancel, or surrender the policy  
☐ Considering a 1035 Exchange or replacement policy  
☐ Cash liquidity preferred due to current financial situation

**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 Welcome Funds Inc'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).

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

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

**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):** \$ \_\_\_\_\_

### 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 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 Welcome Funds Inc d/b/a WFI Life Insurance Services ("WFI") may rely on such information, including but not limited to the Personal Acknowledgements above. I/we will immediately notify WFI of any changes.

I/We give my/our consent to WFI, its agents and/or 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





WELCOME FUNDS INC.  
d/b/a WFI LIFE INSURANCE SERVICES  
6001 BROKEN SOUND PKWY  
SUITE 320  
BOCA RATON, FL 33487

TOLL-FREE: 877.227.4484  
PHONE: 561.862.0244  
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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 life settlement contract is guilty of a crime & may be subject to fines & confinement in prison.***

***You should carefully read all of the following disclosures below  
& seek financial, insurance, tax & other advice where appropriate.***

1. **WFI Life Insurance Services** & your referring advisor/broker, if any, represents exclusively you & not the insurer or provider or any other person & owes you a fiduciary duty, including to act according to your instructions & in your best interest notwithstanding the manner in which **WFI Life Insurance Services** & your referring advisor/broker, if any, is compensated.
2. There may be possible alternatives to life settlements which exist & include, but are not limited to, accelerated death benefit options that may be offered by your life insurer.
3. Some or all of the proceeds of a life settlement may be taxable. **WFI Life Insurance Services** is not a tax advisor & recommends that you consult your own professional tax advisor regarding this transaction.
4. The sale of your insurance policy may affect your eligibility to receive public assistance or other government benefits or entitlements. You should contact the State Department of Health Care Services & the State Department of Social Services under Section 11022 of the Welfare & Institutions Code for further information.
5. Proceeds from a life settlement could be subject to the claims of creditors.
6. Entering into a life settlement contract may cause other rights or benefits, including conversion rights & waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited. Assistance should be sought from a financial adviser.
7. Entering into a life settlement could limit the insured's ability to purchase life insurance in the future because there is a limit to how much coverage insurers will issue on one life.
8. The owner has a right to rescind a life settlement contract within thirty (30) days of the date it is executed by all parties & the owner has received all required disclosures, or fifteen (15) days from receipt by the owner of the proceeds of the life settlement, whichever is sooner. Rescission will only be effective if both notice of rescission is given & all proceeds & any premiums, loans, & loan interest paid on account of the provider are repaid within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to be have been rescinded & subject to repayment by the owner or the owner's estate of all proceeds & any premiums, loans, & loan interest to the provider.
9. Total compensation payable to both **WFI Life Insurance Services** & your referring advisor/broker, if any, shall collectively be calculated as a percentage of the contingent offer obtained for the sale of your existing life insurance policy. Your proceeds are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the life settlement provider reduced by the total compensation as described above. Actual total compensation shall be disclosed no later than the date the life settlement contract is signed by all parties.

**[Additional Disclosures on Next Page]**

## NOTICE OF DISCLOSURE (PAGE 2 OF 2)

10. Proceeds will be sent to the owner within three (3) business days after the provider has received the insurer or group administrator's acknowledgement that ownership of the policy or the interest in the certificate has been transferred & the beneficiary has been designated in accordance with the terms of the life settlement contract. **WFI Life Insurance Services** & your referring advisor/broker, if any, has no access to or control over provider funds set aside in escrow or trust.
11. All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insurer'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 the owner & 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 funds for the purchase. You may be asked to renew your permission to share information every two (2) years. In addition, information regarding the owner's & insured's identity & insured's medical condition will 1) be shared with the insurer that issued the life insurance policy; & 2) shall be available to each subsequent owner of the life insurance policy.
12. The insured may be contacted by either the provider or the broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, & no more than once per month if the insured has a life expectancy of one (1) year or less.
13. The name, business address, & telephone number of **WFI Life Insurance Services** is as follows:

Welcome Funds, Inc. d/b/a WFI Life Insurance Services  
6001 Broken Sound Pkwy  
Suite 320  
Boca Raton, Florida 33487  
Telephone: 877-227-4484  
Fax: 561-862-0242

14. **WFI Life Insurance Services** recommends that you read the life settlement contract & seek assistance from a professional financial advisor &/or consult with your legal advisor prior to signing it.
15. I/we confirm & acknowledge that **WFI Life Insurance Services** has provided me/us with a brochure titled, "Selling Your Life Insurance Policy: Understanding Life Settlements."

*I/We acknowledge that I/we have read & understand the disclosures above (1-15).*

\_\_\_\_\_  
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 WFI Life Insurance Services**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date





WELCOME FUNDS INC.  
d/b/a WFI LIFE INSURANCE SERVICES  
6001 BROKEN SOUND PKWY  
SUITE 320  
BOCA RATON, FL 33487

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WWW.WELCOMEFUNDS.COM

## ADDITIONAL DISCLOSURES, REPRESENTATIONS & ACKNOWLEDGEMENTS (PAGE ONE)

[Please note that #9 may require a response regarding the funding of premiums].

1. **WFI Life Insurance Services** does not provide any advice regarding whether or not to proceed with the life settlement transaction – the policy owner shall reach his/her/its own decision and is free to accept or decline any offer.
2. **WFI Life Insurance Services** does not provide legal, tax, financial, investment and accounting advice and encourages that such advice should be obtained from the appropriate parties to determine, in part, whether the life settlement transaction is more beneficial to the policy owner than other potentially available options.
3. The policy owner did not procure the policy that is the subject of the life settlement transaction with the intent to sell the policy.
4. The policy owner, and not **WFI Life Insurance Services**, is fully responsible for the timely payment of any and all premiums due for the policy that is the subject of the life settlement transaction, on the applicable due dates, up until change of ownership of the policy occurs. The policy owner, not **WFI Life Insurance Services**, assumes sole responsibility if the policy lapses for such lack of timely payment of any and all premiums.
5. There is no pending or threatened action, suit or proceeding against the policy owner that may be reasonably expected to adversely affect the life settlement transaction or the value of the policy that is the subject of the life settlement transaction.
6. The policy that is the subject of the life settlement transaction has had its incidents of ownership at all times retained/maintained by the policy owner, including without limitation, the right to change the owner and the beneficiary of the policy, the right to take out loans under the policy and the right to take all permitted action and exercise all rights of the owner of the policy.
7. No statement or information made or provided by the policy owner to the insurance company that issued the policy that is the subject of the life settlement transaction contained any untrue statement of fact, or omitted to state any fact necessary to make such statement not misleading, true and complete in all respects.
8. If the policy owner is not the original owner of the policy that is the subject of the life settlement transaction, then the policy owner will provide to **WFI Life Insurance Services** the identity of the policy's original owner.
9. Except as noted below, the premiums have been funded by the insured and/or immediate family members of the insured.

Premiums funded by (please provide response here): \_\_\_\_\_

10. **WFI Life Insurance Services** does not determine life expectancies and is not a medical or mortality expert.
11. **WFI Life Insurance Services** does not provide mortality or medical reviews and does not evaluate the health of the insured.
12. It is the responsibility of the policy owner and/or insured to communicate any changes in health of the insured once the life settlement process begins.

[additional disclosures on the following page]

**ADDITIONAL DISCLOSURES, REPRESENTATIONS & ACKNOWLEDGEMENTS (PAGE TWO)**

13. It is the responsibility of the policy owner and/or insured to not withhold from **WFI Life Insurance Services** any medical records material to the estimation of the insured's life expectancy.
14. **WFI Life Insurance Services** is not responsible for the conclusions of life expectancy providers and/or firms that produce life expectancy reports.
15. **WFI Life Insurance Services** does not have the expertise to dispute the conclusions of life expectancy providers and/or firms that produce life expectancy reports.
16. Analysis of life expectancies is conducted by life expectancy providers and/or firms that produce life expectancy reports required and dictated by life settlement providers (or the funding source they represent), not **WFI Life Insurance Services**.
17. The policy owner and insured acknowledge that the insured may live longer or shorter than any life expectancy projection or estimate.
18. Once the life settlement transaction is completed and the applicable rescission period has ended, the policy owner, insured and any beneficiaries previously designated by the policy owner have no right to the death benefit of the applicable life insurance policy or policies that have been sold, unless stated otherwise in the life settlement contract.
19. The policy owner and insured and/or the representatives of each acknowledge that if **WFI Life Insurance Services** is forced to enforce these disclosures, representations and acknowledgements and/or its role as a life settlement broker in a court of law, then the policy owner and/or insured shall be liable for all attorneys' fees and court costs associated with such enforcement incurred by **WFI Life Insurance Services**.
20. The policy owner and insured believe that that selling the policy that is the subject of the life settlement transaction is in their best interest based on their understanding of selling existing life insurance policies, their current financial situation, future needs and their prior investment experience and objectives.

***I/we have read and understand the information above and my/our signatures below have been obtained voluntarily, without coercion and of my/our own free will.***

---

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 WFI Life Insurance Services**

---

Printed Name

---

Date



WELCOME FUNDS INC.  
d/b/a WFI LIFE INSURANCE SERVICES  
6001 BROKEN SOUND PKWY  
SUITE 320  
BOCA RATON, FL 33487

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PHONE: 561.862.0244  
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WWW.WELCOMEFUNDS.COM

## 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 d/b/a WFI Life Insurance Services ("WFI")** 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.*

**WFI** 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 **WFI** 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 **WFI** 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 **WFI**, 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



WELCOME FUNDS INC.  
d/b/a WFI LIFE INSURANCE SERVICES  
6001 BROKEN SOUND PKWY  
SUITE 320  
BOCA RATON, FL 33487

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

## 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:

- 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.
- Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Welcome Funds Inc d/b/a WFI Life Insurance Services** including any of its affiliates, agents, subsidiaries, corporate parents, 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.
- 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.
- 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.
- 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.
- 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)



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## 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:

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- Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Welcome Funds Inc d/b/a WFI Life Insurance Services** including any of its affiliates, agents, subsidiaries, corporate parents, 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.
- 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.
- 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.
- 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.
- 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 **WFI Life Insurance Services** and 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)

**WFI Life Insurance Services** represents the best interests of consumers in an effort to obtain one or more offers for the sale of their policy(ies). As your designated broker, **WFI Life Insurance Services** incurs the necessary, required and related costs to facilitate a life settlement while providing the following services, including but not limited to:

- Qualification analysis and review
- Evaluation Form assessment
- Submission to one or more life settlement providers
- Medical underwriting & insurance verifications
- Closing services including contract review & assistance with requirements of life settlement providers

In consideration of the services provided and related costs incurred as described above, I/We authorize **WFI Life Insurance Services** 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 related to the purchase of the following life insurance policy(ies):

1<sup>st</sup> Policy No. \_\_\_\_\_ issued by \_\_\_\_\_, 2<sup>nd</sup> Policy No. \_\_\_\_\_ issued by \_\_\_\_\_.  
Name of Insurance Carrier (if applicable) Name of Insurance Carrier

By signing this Authorization and Agreement, I/we am/are:

1. Granting to **WFI Life Insurance Services** the authority, for the period of time described above, to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers as determined by **WFI Life Insurance Services**, pursuant to its typical practices, for the sale of my/our life insurance policy(ies) as stated above.
2. Recognizing the proprietary nature of such offers as evaluated, underwritten, solicited, generated and secured by **WFI Life Insurance Services** for the period of time as described above and pursuant to this Agreement.
3. Agreeing to the total compensation, as described in this paragraph, payable to **WFI Life Insurance Services** and your referring advisor/broker, if any. Such compensation shall collectively be calculated as a percentage of the contingent offer obtained for the sale of your existing life insurance policy. Your proceeds are represented by the Net Purchase Price (NPP) as follows:  $NPP = \text{Gross Purchase Price (GPP)} - \text{total compensation}$  as paid by the life settlement provider reduced by the total compensation as described above. Actual total compensation shall be disclosed no later than the date the life settlement contract is signed by all parties.
4. Acknowledging that a) **WFI Life Insurance Services** does not determine life expectancies and is not a medical or mortality expert; b) **WFI Life Insurance Services** does not have the expertise to dispute the conclusions of life expectancy providers; and c) **WFI Life Insurance Services** does not determine or evaluate the insured's health.
5. Aware that **WFI Life Insurance Services** issues 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 **Authorized Representative of WFI Life Insurance Services**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



## 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.