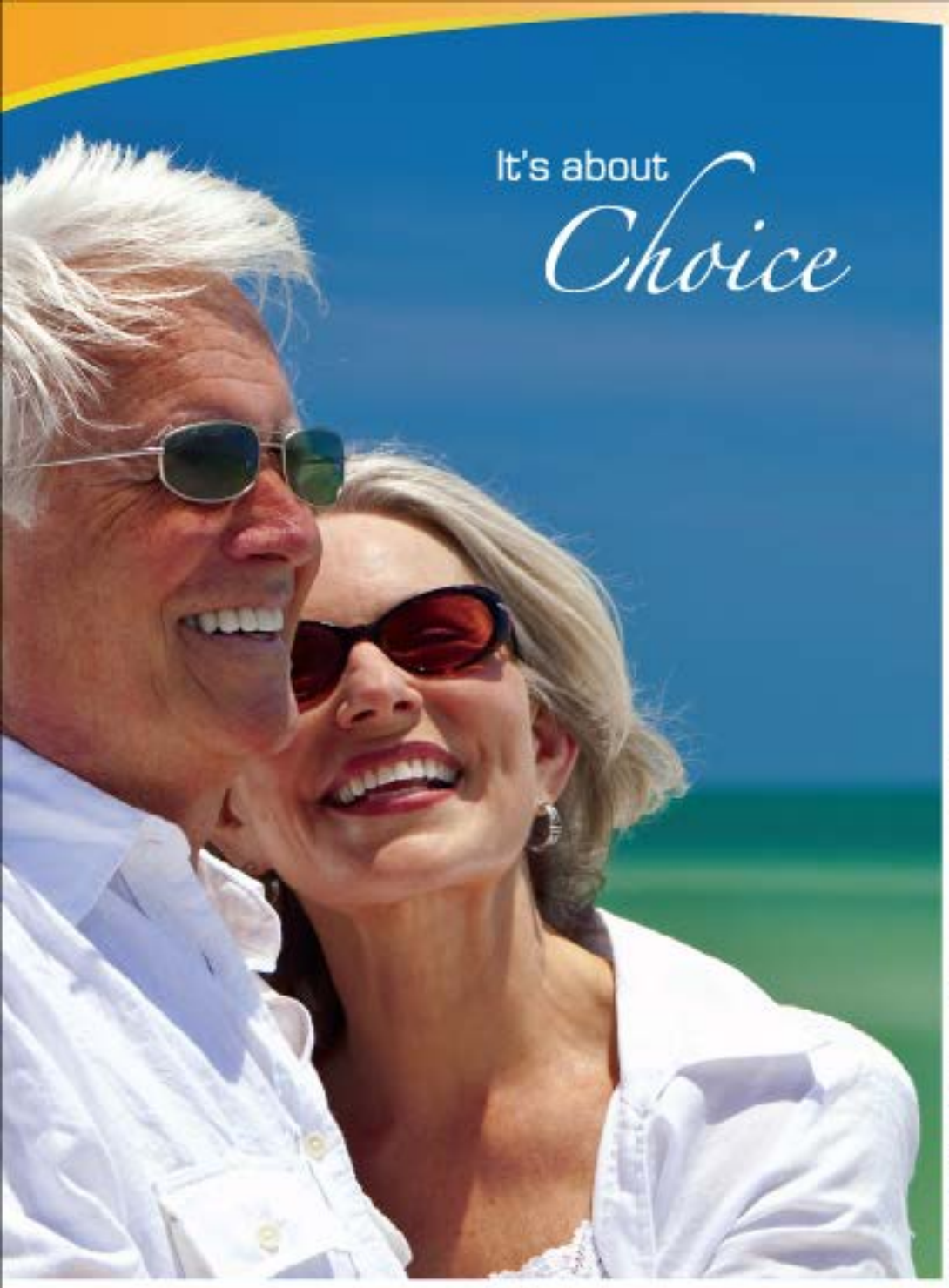

WELCOME FUNDS

Life Settlements. Simplified.®

KENTUCKY
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 Kentucky

Life Settlement Broker License

COMMONWEALTH OF KENTUCKY

MATTHEW G. BEVIN

GOVERNOR

KNOW ALL MEN BY THESE PRESENTS THAT:

WELCOME FUNDS INC.

BOCA RATON, FL

having complied with the necessary provisions of the Insurance Laws of Kentucky, and having produced evidence satisfactory to the Commissioner of Insurance thereof, is hereby granted a license as:

NON-RESIDENT LIFE SETTLEMENT BROKER

and may perform and act as such, subject to the obligations and limitations imposed thereon, by law, for a period beginning on the date of issue herein, and to continue in force as long as the licensee is entitled thereto, under this Code, or until suspension, or revocation, by the Commissioner of Insurance.

DEPARTMENT OF INSURANCE COMMONWEALTH OF KENTUCKY FRANKFORT · KENTUCKY

Nancy G. Atkins

Commissioner

This license shall at all times be the property of the Commonwealth of Kentucky, and upon any expiration, suspension, revocation, or termination thereof, the licensee shall promptly deliver said license to the Commissioner of Insurance.

DOI ID : 694373 Print Date : 4/5/2018

NPN ID :

#881049-10-1

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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:

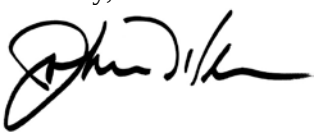
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the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

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

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

PLEASE CHECK APPICABLE RELATIONSHIP TO PRIMARY INSURED (IF APPLICABLE)

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

LIFE INSURANCE POLICY INFORMATION

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

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

☐ Individual ☐ Joint Survivorship ☐ Group ☐ Other_____

TYPE OF POLICY (PLEASE CHECK ONE)

IF A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP

☐ Term ☐ WL ☐ UL ☐ Other:_____

CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

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

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

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

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

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

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

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

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

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

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

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

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

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

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

☐ YES ☐ NO ☐ YES ☐ NO Date:_____

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

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

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

☐ Planning to lapse, cancel, or surrender the policy

☐ Health & living expenses are a financial burden

☐ Considering a 1035 Exchange or replacement policy

☐ Interested in learning market value of policy

☐ Cash liquidity preferred due to current financial situation

☐ Other or provide further details: _____

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

If the information below is not completed, then the policy owner(s) and insured(s) acknowledge that Welcome Funds Inc may not be able 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. FINANCIAL 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%] ☐ Other

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

III. LIFE INSURANCE

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

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
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) 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 may rely on such information, including but not limited to the Personal Acknowledgements above. I/we will immediately notify WELCOME FUNDS INC of any changes.

I/We give my/our consent to WELCOME FUNDS INC, 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.
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BOCA RATON, FL 33431

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WWW.WELCOMEFUNDS.COM

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.

1. There are possible alternatives to life settlement contracts including but not limited to accelerated benefits or policy loans offered under your policy.

2. Some or all of the proceeds of the life settlement may be taxable under federal income tax laws and state franchise and income tax laws. WELCOME FUNDS INC is not a tax advisor and assistance should be sought from a personal tax advisor.

3. Proceeds of the life settlement contract could be subject to the claims of creditors.

4. Receipt of proceeds of a life settlement contract may adversely affect the owner's eligibility for Medicaid or other government benefits or entitlements. Advice should be obtained from the appropriate government agencies.

5. Life settlement proceeds could be subject to the claims of creditors.

6. The owner has a right to cancel a life settlement contract before the earlier of 30 calendar days of the date it is executed by all parties or 15 calendar days after receipt of the proceeds of the life settlement contract by the owner.

7. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy, to be forfeited by the owner. Assistance should be sought from a financial advisor.

8. Funds will be sent to the owner within three (3) business days after the life settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy has been transferred and the beneficiary has been designated pursuant to the life settlement contract. WELCOME FUNDS INC has no access to or control over life settlement provider funds that are set aside in escrow or trust.

9. Total life settlement broker compensation shall be disclosed no later than the date the life settlement contract is signed by all parties.

10. All medical, financial or personal information solicited or obtained by a life settlement provider or WELCOME FUNDS INC about the insured, including the insured's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the life settlement between you and the life settlement provider. If you are asked to provide this information, you will be asked to consent to this disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years. In addition, information regarding your and the insured's identity and insured's medical condition will 1) be shared with the insurer that issued the life insurance policy; and 2) shall be available to each subsequent owner of the life insurance policy.

[Additional Disclosures on Next Page]

NOTICE OF DISCLOSURE (PAGE 2 OF 2)

11. The insured may be contacted by the life settlement provider or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact will be limited to no more frequently than once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.

12. WELCOME FUNDS INC recommends that the owner read the life settlement contract and seek assistance from a professional financial advisor and/or consult with a legal advisor prior to signing it.

13. I/we confirm and acknowledge that WELCOME FUNDS INC has provided me/us with the most recent brochure developed by the Kentucky Department of Insurance titled, "Kentucky Consumer Guide to Understanding Life Settlements.

I/We acknowledge that I/we have read and understand the disclosures above (1-13).

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

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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

Life Insurance Company _____ **Policy Number** _____

Printed Name of All Policy Owner(s) _____ **Printed Name of Insured(s)** _____

By signing this release, I/we authorize the life insurance company named above and any other company or person that has information related to the life insurance policy named above to:

a) release such information to WELCOME FUNDS INC and its authorized representatives; and

b) reply immediately to any request for information or documents required by WELCOME FUNDS INC relating to the life insurance policy named above.

The information to be released includes but is not limited to the following:

a) original copy of the policy; b) applications for insurance; c) riders; d) current and projected illustrations; e) conversions; f) withdrawals; g) lapse or reinstatement coverage; h) verification of coverage; i) change in ownership and beneficiary; j) assignments; k) premium payments and payment provisions; l) contestable and suicide status; and m) any and all other information.

In addition, I/we authorize:

a) WELCOME FUNDS INC to share the information it receives with any other company or person for the purpose of evaluating all of my options related to the policy named above;

b) that this Authorization shall remain valid until (i) I/we withdraw our consent, pursuant to applicable law; or (ii) the death of the Insured (or if multiple Insureds, until the death of the last to survive), unless any applicable state statute or regulation requires a different time period. If a different time period is required, this Authorization shall remain valid for the maximum period allowed per state statute or regulation;

c) that a photocopy, PDF or electronic file or fax of this Authorization is as valid as an original.

Furthermore, I/we certify:

a) that this Authorization is being executed and delivered freely as of the date written below; and

b) understand the contents of this Authorization in full.

WELCOME FUNDS INC

Authorized By:

Signature of **Primary Insured** _____ Printed Name _____ Date _____

Signature of **Secondary Insured** (if applicable) _____ Printed Name _____ Date _____

Signature of **Policy Owner #1** (if not Insured) _____ Printed Name _____ Date _____

Signature of **Policy Owner #2** (if not Insured) _____ Printed Name _____ Date _____

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION PRIMARY INSURED ("Release")

I, _____ (Insured), _____ (Date of Birth) _____ (SS #) authorize the disclosure to Welcome Funds Inc. ("WFI") of my protected health information as defined under the privacy regulations for all purposes of the Federal Health Insurance Portability and Accountability Act of 1996 ("1996 ACT") also known as HIPAA. I understand that my health information under this Release 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.

I. **The term, "WFI" shall include but not be limited to the following with respect to WFI under this Release**.
A. Its successors or assigns. B. Its agents and/or affiliates. C. Its officers. D. Its employees. E. Its subsidiaries and corporate parents. F. Its independent contractors or consultants. G. Its third party life expectancy and service providers. H. Its providers or financing sources (and any third party in connection with such financing). I. Other WFI authorized entities or authorized representatives and/or their agents. J. Other persons or entities needing to receive, evaluate, underwrite or solicit bids for a sale of any life insurance policy.

II. **Authorized parties who may release my medical records include the following (collectively, the "Directed Persons").**
A. Insurance companies. B. Medical Information Bureau. C. Any other institution or person with my medical records or information, including the following. 1. Physicians. 2. Doctors. 3. Physicians practice groups. 4. Nurses. 5. Pharmacies. 6. Clinics. 7. Medical centers. 8. Hospitals. 9. Any other health care provider. I acknowledge that Directed Persons shall be guided by instructions provided by WFI, as the request using this Release is as valid as if I had requested my own medical records.

III. **Medical records consist of all records concerning my past, present or future physical or mental history or condition as to diagnosis, treatment and/or prognosis ("Medical Records"). Medical Records include but are not limited to the following.**
A. X-rays. B. Charts. C. Medical Files/Records. D. Hospital records. E. Laboratory tests and results. F. Test and examination reports. G. Problem lists. H. Information relating to the following. a. Sexually transmitted diseases. b. Psychiatric evaluations, treatment and/or information. I. And any and all of my health and medical data and information and records. This Release shall also serve as my written consent to disclosure of drug, alcohol or HIV related information and medical records. Medical Records include but are not limited to private, privileged, protected or personal health information defined as "Protected Health Information" under this Release and the 1996 ACT whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

IV. **Authorized recipients of information from WFI under this Release may include the following but will not be limited to and can be used for the purpose listed below.**
A. medical underwriters. B. lenders. C. financing entities. D. brokers/brokerages. E. buyers of life insurance policies. F. life expectancy providers. G. stop-loss re-insurers. Each will include their. 1. affiliates. 2. agents. 3. subsidiaries. 4. corporate parents. 5. independent contractors. 6. consultants. 7. service providers. 8. authorized representatives. 9. officers. 10. directors. 11. employees. Each an ("Authorized Recipient"). This Release and all disclosures of my Medical Records made under this Release are for purposes of allowing the Authorized Recipient to. a. analyze. b. assess. c. evaluate or underwrite my health/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. As a result of this Release, my ongoing health status may be tracked by WFI or Authorized Recipient.

V. **Expiration of Release, right to remove Release, and additional items.**
This Release shall be valid until the Insured's death or the maximum time allowed by state or federal law. I understand that I may remove this Release at any time by notifying any Directed Persons in writing of my removal and by delivering the removal document by mail or personal delivery to any Directed Persons. I also understand that if Directed Persons have already released Medical Records that any removal of Release shall not cover that situation. This Release is not a consent or authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the 1996 Act. As a result of this Release, either of the following may occur with respect to Medical Records disclosed by the Directed Persons or other covered entity (as defined under the 1996 Act) to WFI. a. They may be redisclosed. b.They may no longer be protected by privacy laws provided by law, including but not limited to the 1996 Act.

I certify that I am executing this Release freely and unilaterally as of the date written below. This Release is written in plain language. I fully understand the contents of this Release. I had the opportunity to consult with an attorney prior to signing this Release. I agree that all Directed Persons can rely upon a fax or copy or other reproduction of this Release.

_____

List of Directed Persons (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 ("Release")

I, _____ (Insured), _____ (Date of Birth) _____ (SS #) authorize the disclosure to Welcome Funds Inc. ("WFI") of my protected health information as defined under the privacy regulations for all purposes of the Federal Health Insurance Portability and Accountability Act of 1996 ("1996 ACT") also known as HIPAA. I understand that my health information under this Release 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.

I. <u>The term, "WFI" shall include but not be limited to the following with respect to WFI under this Release</u>.

A. Its successors or assigns. B. Its agents and/or affiliates. C. Its officers. D. Its employees. E. Its subsidiaries and corporate parents. F. Its independent contractors or consultants. G. Its third party life expectancy and service providers. H. Its providers or financing sources (and any third party in connection with such financing). I. Other WFI authorized entities or authorized representatives and/or their agents. J. Other persons or entities needing to receive, evaluate, underwrite or solicit bids for a sale of any life insurance policy.

II. <u>Authorized parties who may release my medical records include the following (collectively, the "Directed Persons").</u>

A. Insurance companies. B. Medical Information Bureau. C. Any other institution or person with my medical records or information, including the following. 1. Physicians. 2. Doctors. 3. Physicians practice groups. 4. Nurses. 5. Pharmacies. 6. Clinics. 7. Medical centers. 8. Hospitals. 9. Any other health care provider. I acknowledge that Directed Persons shall be guided by instructions provided by WFI, as the request using this Release is as valid as if I had requested my own medical records.

III. <u>Medical records consist of all records concerning my past, present or future physical or mental history or condition as to diagnosis, treatment and/or prognosis ("Medical Records"). Medical Records include but are not limited to the following.</u>

A. X-rays. B. Charts. C. Medical Files/Records. D. Hospital records. E. Laboratory tests and results. F. Test and examination reports. G. Problem lists. H. Information relating to the following. a. Sexually transmitted diseases. b. Psychiatric evaluations, treatment and/or information. I. And any and all of my health and medical data and information and records. This Release shall also serve as my written consent to disclosure of drug, alcohol or HIV related information and medical records. Medical Records include but are not limited to private, privileged, protected or personal health information defined as "Protected Health Information" under this Release and the 1996 ACT whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

IV. <u>Authorized recipients of information from WFI under this Release may include the following but will not be limited to and can be used for the purpose listed below.</u>

A. medical underwriters. B. lenders. C. financing entities. D. brokers/brokerages. E. buyers of life insurance policies. F. life expectancy providers. G. stop-loss re-insurers. Each will include their. 1. affiliates. 2. agents. 3. subsidiaries. 4. corporate parents. 5. independent contractors. 6. consultants. 7. service providers. 8. authorized representatives. 9. officers. 10. directors. 11. employees. Each an ("Authorized Recipient"). This Release and all disclosures of my Medical Records made under this Release are for purposes of allowing the Authorized Recipient to. a. analyze. b. assess. c. evaluate or underwrite my health/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. As a result of this Release, my ongoing health status may be tracked by WFI or Authorized Recipient.

V. <u>Expiration of Release, right to remove Release, and additional items.</u>

This Release shall be valid until the Insured's death or the maximum time allowed by state or federal law. I understand that I may remove this Release at any time by notifying any Directed Persons in writing of my removal and by delivering the removal document by mail or personal delivery to any Directed Persons. I also understand that if Directed Persons have already released Medical Records that any removal of Release shall not cover that situation. This Release is not a consent or authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the 1996 Act. As a result of this Release, either of the following may occur with respect to Medical Records disclosed by the Directed Persons or other covered entity (as defined under the 1996 Act) to WFI. a. They may be redisclosed. b.They may no longer be protected by privacy laws provided by law, including but not limited to the 1996 Act.

I certify that I am executing this Release freely and unilaterally as of the date written below. This Release is written in plain language. I fully understand the contents of this Release. I had the opportunity to consult with an attorney prior to signing this Release. I agree that all Directed Persons can rely upon a fax or copy or other reproduction of this Release.

_____

List of Directed Persons (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

BROKER AUTHORIZATION & SERVICES AGREEMENT

Do you have a referring advisor/broker working with WELCOME FUNDS INC 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) _____

WELCOME FUNDS INC 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, WELCOME FUNDS INC 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 WELCOME FUNDS INC 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):

1st Policy No. _____ issued by _____. 2nd 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 WELCOME FUNDS INC the authority, for the period of time described above, to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers as determined by WELCOME FUNDS INC, pursuant to its typical 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 WELCOME FUNDS INC 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 WELCOME FUNDS INC 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 = 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.
4. Aware that WELCOME FUNDS INC 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 Officer of WELCOME FUNDS INC**	Printed Name	Date

KENTUCKY CONSUMER GUIDE TO UNDERSTANDING LIFE SETTLEMENTS

Commonwealth of Kentucky

Public Protection Cabinet

Kentucky UNBRIDLED SPIRIT™

Defining the Terms

A **life settlement** (which includes viatical settlements) occurs when a person sells his or her life insurance policy to a third party. The owner of the insurance policy sells the policy for a cash payment that is less than the full amount of the death benefit.

A **life settlement** provider is the person or company who buys the life insurance policy. The life settlement provider becomes the new owner and has control over the policy including naming a beneficiary.

The **life settlement contract** is the agreement in which the life settlement provider agrees to purchase all or a portion of the life insurance policy and the owner agrees to sell all or a portion of the life insurance policy.

The **life settlement broker** can assist an owner of a life insurance policy in searching for the right life settlement provider to purchase the policy. The life settlement broker then will receive a commission for helping with the sale. The life settlement broker has a legal obligation to find the best deal for the owner of the life insurance policy.

The person selling the life insurance policy is the **owner** of the life insurance policy. The owner will receive a settlement payment for the sale of the policy, which will be an amount that is less than the face amount of the life insurance policy.

Understanding Life Settlements

A viatical settlement is the sale of a life insurance policy to a third party. The owner of the life insurance policy sells it for a payment that is less than the full amount of the death benefit. The buyer becomes the new owner and has the right to make any changes to the life insurance policy including naming the beneficiary.

People decide to sell their life insurance policies for many reasons. Some of those reasons may be changing needs of dependents, wanting to reduce insurance premiums or needing to raise cash for expenses. People with a terminal or chronic illness may want to sell their policy in order to pay medical bills. Before making the decision to sell a life insurance policy, always check for alternatives. There may be an option in the life insurance policy to accelerate death benefits.

Be sure you fully understand life settlements before you make any decisions.

A life settlement may or may not be the right choice for you. The Kentucky Department of Insurance, along with the National Association of Insurance Commissioners (NAIC), is concerned that many consumers may not fully understand life settlements. In addition, some or all of the proceeds of a life settlement may be taxable, and receipt of life settlement proceeds may affect your eligibility for Medicaid or other government benefits. Please be sure to check with a financial professional before making any decision.

Consumer Tips

- ➲ Understand how the process works and read all documents carefully.
- ➲ 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 do not use a life settlement broker, comparison shop on your own.
- ➲ You do not have to accept any life settlement offer.
- ➲ Be sure to read through the life settlement application for accuracy, especially information about your medical history.
- ➲ Understand that you have the ability to cancel the contract within the first 30 days after you have signed a contract or 15 days after you have received the settlement money.
- ➲ Understand that buyers will have access to your medical information and they have the right to contact you as often as every 3 months to discuss any changes in your medical information.

Consumer Alert

Be cautious if you are:

* asked to invest in or buy a life settlement contract;
* interested in selling your life insurance policy and want more information; or
* contacted by someone who wants you to buy a life insurance policy then immediately sell that policy as a life settlement transaction.

Additional Questions to Consider

- ? Do I still need life insurance protection?
- ? How does the life settlement provider decide how much cash my policy is worth?
- ? Do different life settlement providers make different offers?
- ? What costs including commissions will I have to pay if I sell my policy?
- ? Are the life settlement provider and/or broker licensed in Kentucky?
- ? Who will become the legal owner of the policy if I sell it?
- ? How often will I be contacted to determine my continuing health condition?
- ? After I sell my policy, can it be resold?
- ? Will I always know who owns the policy?

Steps in the Life Settlement Process

1. A written statement from a licensed attending physician that you are of sound mind to sell your policy.
2. Sign a contract in which you:
   a. consent to the life settlement contract
   b. verify any catastrophic or life threatening illness was diagnosed after the policy was issued
   c. confirm that you fully understand the life settlement contract
   d. release your medical records
   e. acknowledge that you entered into the life settlement contract freely and voluntarily

Explore All Your Options: A Checklist

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, such as accelerated benefits. It could pay you a substantial portion of your policy's death benefit without selling your policy to a third party. Also ask if there is any cash value in your 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. You also may be able to use the cash value as security for a loan from a financial institution.
- ❒ Contact a licensed life settlement broker or licensed life settlement provider for information about life settlements.
- ❒ Consult with your own financial adviser who knows your personal financial needs. Be sure to ask about tax and other financial consequences if you sell your policy. Contact a professional tax adviser to find out the tax implications. Proceeds are only tax-free under certain circumstances.
- ❒ Contact the Kentucky Department of Insurance at 800-595-6053 for information about current laws that may protect you.

Other Things to Consider

- ❒ Know that your creditors could claim the proceeds.
- ❒ Find out if you will lose any Medicaid benefits.
- ❒ Find out if you will lose any public assistance benefits.
- ❒ Know that you must provide certain medical and personal information to third parties who will receive 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.

Kentucky Public Protection Cabinet
Department of Insurance
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http://insurance.ky.gov/

Printed with state funds on recycled paper

August 2008