

It's about
Choice



WELCOME
FUNDS

Life Settlements. Simplified.®



**MISSISSIPPI
STATE APPLICATION**

1.877.227.4484

welcomefunds.com

State of Mississippi

Viatical Settlement Broker License



MISSISSIPPI

INSURANCE DEPARTMENT

Mike Chaney
Commissioner of Insurance

Mark Haire
Deputy Commissioner of Insurance

License

WELCOME FUNDS INC.

License Number: 15010378 NPN: 3421401

is licensed to engage in the business of insurance in the State of Mississippi in the capacity stated below,
subject to applicable laws and rules.

	Effective Date	Expiration Date
Licensed as: Insurance Producer Entity	10-27-2009	05-31-2025
Qualified for:		

Commissioner of Insurance

Mississippi Insurance Department



WELCOME FUNDS INC.
LICENSE NUMBER: 15010378 NPN: 3421401

	Effective Date	Expiration Date
Licensed as/ Qualified for: Insurance Producer Entity	10-27-2009	05-31-2025

A LETTER FROM THE FOUNDER

Dear Policy Owner/Insured:

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

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

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

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

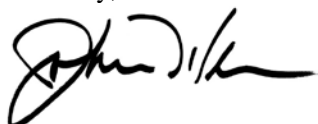
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the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

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

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

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

Sincerely,



John M. Welcom
Founder & CEO



WELCOME FUNDS INC.
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

EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

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

PRIMARY INSURED'S INFORMATION

PRIMARY INSURED NAME (FULL LEGAL NAME)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	
CURRENT HOME ADDRESS	CITY	STATE	ZIP CODE	
PRIMARY ATTENDING PHYSICIAN	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER

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

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed

PLEASE CHECK APPLICABLE MARITAL STATUS

IF MARRIED/DIVORCE/WIDOWED, PLEASE PROVIDE FULL NAME OF (EX)SPOUSE

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

SECONDARY INSURED NAME (FULL LEGAL NAME)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	
CURRENT HOME ADDRESS	CITY	STATE	ZIP CODE	
PRIMARY ATTENDING PHYSICIAN	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER
OTHER PHYSICIANS SEEN IN LAST 5 YEARS	SPECIALTY	CITY/STATE	DATE LAST SEEN	TELEPHONE NUMBER

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

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

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

PLEASE CHECK APPLICABLE RELATIONSHIP TO PRIMARY INSURED (IF APPLICABLE)

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

LIFE INSURANCE POLICY INFORMATION

LIFE INSURANCE COMPANY	FACE AMOUNT	POLICY NUMBER	ISSUE DATE
			<input type="checkbox"/> YES <input type="checkbox"/> NO
POLICY LOAN AMOUNT (IF ANY)	ACCUMULATED/CASH VALUE (IF ANY)	CASH SURRENDER VALUE (IF ANY)	CASH VALUE USED TO PAY PREMIUMS?
<input type="checkbox"/> Individual	<input type="checkbox"/> Joint Survivorship	<input type="checkbox"/> Group	<input type="checkbox"/> Other: _____
TYPE OF POLICY (PLEASE CHECK ONE)			
IF A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP OR YOUR HR DEPT. CONTACT			
<input type="checkbox"/> Term	<input type="checkbox"/> WL	<input type="checkbox"/> UL	<input type="checkbox"/> Other: _____
CLASSIFICATION OF POLICY (PLEASE CHECK ONE)			
<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly
POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX)			\$ _____
PREMIUM AMOUNT			
PLEASE PROVIDE NAMES AND RELATIONSHIP OF ALL PRIMARY BENEFICIARIES OF POLICY (IF IT IS A TRUST, PROVIDE TRUST NAME AND NAME & ADDRESS OF TRUSTEE(S))			
ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES			

POLICY OWNER INFORMATION

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

LEGAL NAME OF POLICY OWNER # 1	RELATIONSHIP TO INSURED	SOCIAL SECURITY NUMBER
POLICY OWNER # 1 ADDRESS	CITY	STATE
	ZIP CODE	TELEPHONE NUMBER
LEGAL NAME OF POLICY OWNER # 2 (IF APPLICABLE)	RELATIONSHIP TO INSURED	SOCIAL SECURITY NUMBER
POLICY OWNER # 2 ADDRESS	CITY	STATE
	ZIP CODE	TELEPHONE NUMBER
IF THERE ARE MORE INDIVIDUAL POLICY OWNERS, THEN PLEASE LIST ALL NAMES AND STATES OF RESIDENCE		
<input type="checkbox"/> Family Member	<input type="checkbox"/> Spouse	<input type="checkbox"/> Business Partner
<input type="checkbox"/> Policy Owner is Insured	<input type="checkbox"/> Other: _____	
IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK APPLICABLE RELATIONSHIP TO INSURED		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Divorced – Date: _____	
IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK MARITAL STATUS		
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Date: _____		
HAS A POLICY OWNER EVER DECLARED BANKRUPTCY?	IF SO, HAS IT BEEN DISCHARGED?	(PLEASE PROVIDE ALL BANKRUPTCY DOCS)
		WHEN WAS IT DISCHARGED?

If Corporate or Trust Owned:

LEGAL NAME OF COMPANY OR TRUST	RELATIONSHIP TO INSURED	TAX ID NUMBER
COMPANY OR TRUST ADDRESS (OFFICIAL DOMICILE)	CITY	STATE
	ZIP CODE	TELEPHONE NUMBER
LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 1	LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 2	
TRUSTEE # 1 ADDRESS (IF DIFFERENT THAN TRUST)	CITY	STATE
	ZIP CODE	TELEPHONE NUMBER
TRUSTEE # 2 ADDRESS (IF DIFFERENT THAN TRUST)	CITY	STATE
	ZIP CODE	TELEPHONE NUMBER

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

ADDITIONAL INFORMATION

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

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

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

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

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

Primary Insured: ☐ Yes ☐ No
Secondary Insured (if applicable): ☐ Yes ☐ No

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

If **Yes**, then please:

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

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

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

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

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

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

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

If **Yes**, then please:

- a) attach all loan documents, including contracts, trusts and/or corporate documents; and
- b) provide the name of the lender/financing company: _____

Name of **Lender/Financing Company**

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

☐ Yes ☐ No

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

Name of **Lienholder/Assignee**

PLEASE VERIFY YOUR MARKET REPRESENTATION:

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

☐ Yes ☐ No

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

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

PERSONAL ACKNOWLEDGEMENTS

- A. I/We represent that the information contained in this Evaluation Request for Sale of Existing Life Insurance is correct and accurate and acknowledge that WELCOME FUNDS INC may rely on such information as my/our broker for the potential sale of my/our life insurance policy. I/we also acknowledge that it is my/our responsibility to notify WELCOME FUNDS INC of any changes to this information, including any changes in health of the insured after this form has been submitted.
- B. I/We understand that the market value of my/our life insurance policy is based in part on the health status and life expectancy of the insured. Current medical records for the insured are vital to obtain life expectancy assessments. These assessments are conducted by independent third-party life expectancy providers as required by the marketplace. WELCOME FUNDS INC is not responsible for the conclusions of these life expectancy providers and does not have the expertise to dispute those conclusions.
- C. I/We acknowledge that WELCOME FUNDS INC is my/our broker who represents my/our best interests during the entire transaction process. I/We also understand and acknowledge that WELCOME FUNDS INC issues no guarantee that an offer will be secured for my/our policy.
- D. I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial, insurance, medical and personal information gathered from this Evaluation Request for Sale of Existing Life Insurance, including but not limited to medical records, notes and lab reports pertaining to the insured's health, to the appropriate parties who have an identifiable need to review the information.
- E. I/We acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my/our contract for the sale of my/our existing life insurance policy if my/our policy is purchased. In addition, I/we have been advised that I/we may obtain a copy, upon request, of any written agreement that I/we enter into regarding or relating to the sale of my/our existing life insurance policy(ies).
- F. I/We acknowledge that I/we have been provided the following address/department to direct any consumer complaints that I/we may have: WELCOME FUNDS INC c/o Customer Complaints, to 4755 Technology Way – Suite 202, Boca Raton, FL 33431.
- G. I/We understand and acknowledge that WELCOME FUNDS INC does not provide any advice as to whether or not to proceed with the sale of my/our life insurance policy and I/we are free to accept or decline any offer.
- H. I/We understand and acknowledge that the policy owner is fully responsible for the timely payment of any and all premiums due for the policy that is the subject of this potential transaction, on the applicable due dates, up until change of ownership of the policy occurs, if a transaction is effectuated. I/We, not WELCOME FUNDS INC, assume sole responsibility if the policy lapses for failure to make timely payment of any and all premiums.
- I. I/We would like to consider the following options in addition to a lump sum cash settlement offer (*subject to availability based on state residency, policy types and qualification requirements*):
- ☐ Retained Death Benefit (RDB) ☐ Cash Settlement with RDB ☐ Life Insurance Loan/Credit Line
- ☐ Expedited Bid Program (*may require additional disclosures*)

Fraud Warning: Any person who knowingly presents false information in an application for insurance or a viatical/life settlement contract is guilty of a crime & may be subject to fines & confinement in prison.

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

Signature of **Primary Insured**

Printed Name

Date

Signature of **Secondary Insured** (if applicable)

Printed Name

Date

Signature of **Policy Owner #1** (if not Insured)

Printed Name

Date

Signature of **Policy Owner #2** (if applicable & if not Insured)

Printed Name

Date



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

TOLL-FREE: 877.227.4484
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WWW.WELCOMEFUNDS.COM

MISSISSIPPI -- NOTICE OF DISCLOSURE

1. WELCOME FUNDS INC and your referring advisor/broker, if any, represents only you and shall act according to your instructions and in your best interest notwithstanding the manner in which WELCOME FUNDS INC and your referring advisor/broker, if any, is compensated.
2. Some or all of the proceeds of your viatical/life settlement may be taxable under federal income tax and/or state franchise and income tax laws. WELCOME FUNDS INC is not a tax advisor and recommends that you consult your own professional tax advisor regarding this transaction.
3. The sale of your insurance policy may affect your right to receive Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Viatical/life settlement proceeds could be subject to the claims of creditors.
5. There may be possible alternatives to selling your life insurance. This may include the option of an accelerated death benefit or policy loans offered by your life insurance company. You are advised to consult a financial advisor, certified public accountant and/or an attorney regarding these potential alternatives.
6. Once you have received your proceeds from the sale of your life insurance policy, you will have fifteen (15) days from receipt of the viatical/life settlement proceeds in which to rescind the transaction as provided by Mississippi Law.
7. Funds will be sent to you within two (2) business days after the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated. WELCOME FUNDS INC and your referring advisor/broker, if any, has no access to or control over viatical/life settlement provider funds that are set aside in escrow or trust.
8. Entering into a viatical/life settlement contract may 1) cause other rights or benefits, including conversion rights and waiver of premium benefits, which may exist under the policy or a certificate of a group life insurance policy to be forfeited; and 2) reduce the insured's ability to obtain additional life insurance coverage in the future.
9. Total compensation payable to WELCOME FUNDS INC and your referring advisor/broker, if any, shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds of your settlement are represented by the Net Purchase Price (NPP) as follows: $NPP = \text{Gross Purchase Price (GPP)} \text{ as paid by the viatical/life settlement provider reduced by the total compensation as described above.}$
10. All medical, financial or personal information solicited or obtained by a viatical/life settlement provider, WELCOME FUNDS INC. and/or a referring advisor/broker 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 viatical/life settlement between you and the viatical/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. Check your contract to see if and when your permission to share information may be requested for renewal. In addition, information regarding the policy owner's and insured's identity and insured's medical condition will 1) be shared with the insurer that issued the life insurance policy; and 2) shall be available to each subsequent owner of the life insurance policy.
11. The insured may be contacted by the viatical/life settlement provider or WELCOME FUNDS INC or its authorized representative for the purpose of determining the insured's health status. The contract will define the contact limitations in detail.
12. Any person who knowingly presents false information in an application for a viatical/life settlement contract is guilty of a crime and may be subject to penalty, including but not limited to fines and confinement in prison.
13. WELCOME FUNDS INC recommends that you read the viatical/life settlement contract and seek assistance from a professional financial advisor and/or consult with your legal advisor prior to signing it.
14. I/we confirm and acknowledge that WELCOME FUNDS INC has provided me/us with the most recent brochure developed and/or approved by the National Association of Insurance Commissioners (NAIC) describing the process of viatical/life settlements.

I/We acknowledge that I/we have read and understand the disclosures above (1-14).

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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4755 TECHNOLOGY WAY
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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

Life Insurance Company

Policy Number

Printed Name of All Policy Owner(s)

Printed Name of Insured(s)

I/we (the undersigned individual(s)) hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy to release such information to and reply immediately to any written, telephonic or other request for information or documents required by WELCOME FUNDS INC and/or its authorized representatives pertaining to the above-referenced life insurance policy that I/we own.

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

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

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

Authorized By:

Signature of Policy Owner #1

Printed Name

Date

Signature of Policy Owner #2 (if any)

Printed Name

Date



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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (the undersigned individual), DOB _____ SS# _____, hereby authorize disclosure, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, of my protected health information ("PHI") as follows:

- Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
- Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Welcome Funds Inc** including a) any of its affiliates, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, buyers of life insurance policies, life expectancy providers, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
- Description of PHI Authorized for Disclosure and Purpose of Disclosure.** This authorization shall apply to any and all of my health, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing an Authorized Recipient to a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
- Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
- Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted in reliance upon this authorization prior to receiving written notice of my revocation.
- Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that a) this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA"); b) as a result of this Authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA or other privacy laws and regulations; and c) my ongoing health status may be tracked as a result of this Authorization.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

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

Authorized by:

Signature of **Individual** (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 DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (the undersigned individual), DOB _____ SS# _____, hereby authorize disclosure, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, of my protected health information ("PHI") as follows:

- Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
- Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Welcome Funds Inc** including a) any of its affiliates, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, buyers of life insurance policies, life expectancy providers, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
- Description of PHI Authorized for Disclosure and Purpose of Disclosure.** This authorization shall apply to any and all of my health, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing an Authorized Recipient to a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
- Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
- Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted in reliance upon this authorization prior to receiving written notice of my revocation.
- Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that a) this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA"); b) as a result of this Authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA or other privacy laws and regulations; and c) my ongoing health status may be tracked as a result of this Authorization.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

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

Authorized by:

Signature of **Individual** (Second Insured)

Printed Name

Date

Signature of **Legal Representative** of Second Insured (if any)

Printed Name

Date

Description of Legal Representative's **Authority** (if any):

(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)



Selling Your Life Insurance Policy

Understanding Viatical Settlements

What is a Viatical Settlement?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (*viator*) of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the viatical settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company 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. You may also be able to use the cash value as security for a loan from a financial institution.
2. Find out if your life insurance policy has an *accelerated death benefit*. An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.

Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of viatical settlement providers and brokers that are licensed to do business in the state. Contact them to make sure yours are on the list.

Always Check with Your State

- Contact your state insurance or securities departments to learn about the issues and risks of viatical settlements if:
- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy *and* your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy and immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state insurance department before you make a decision.