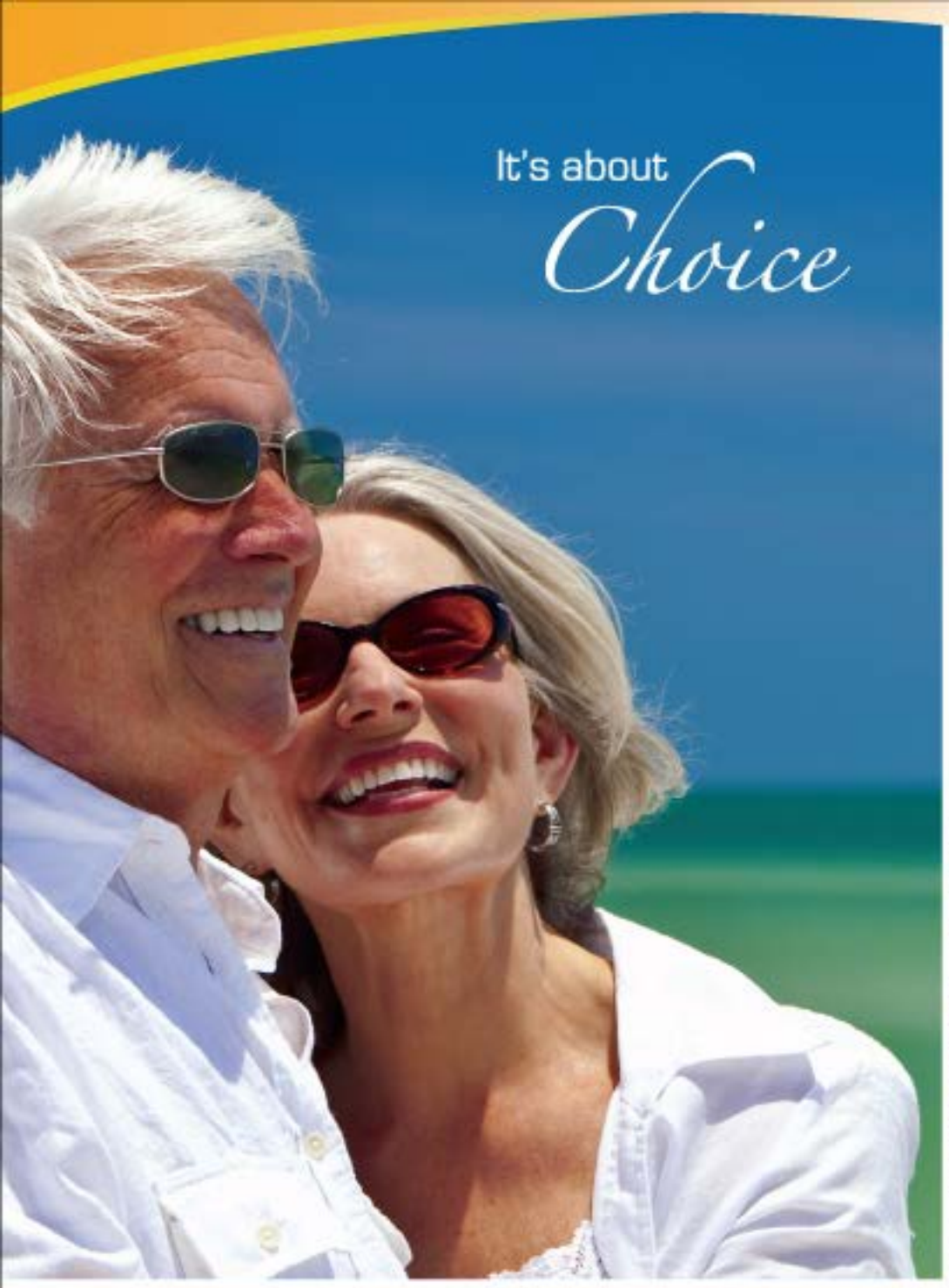


WELCOME FUNDS

Life Settlements. Simplified.®

WASHINGTON STATE APPLICATION

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

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:

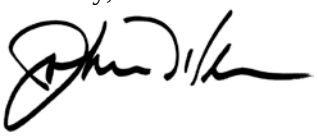
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the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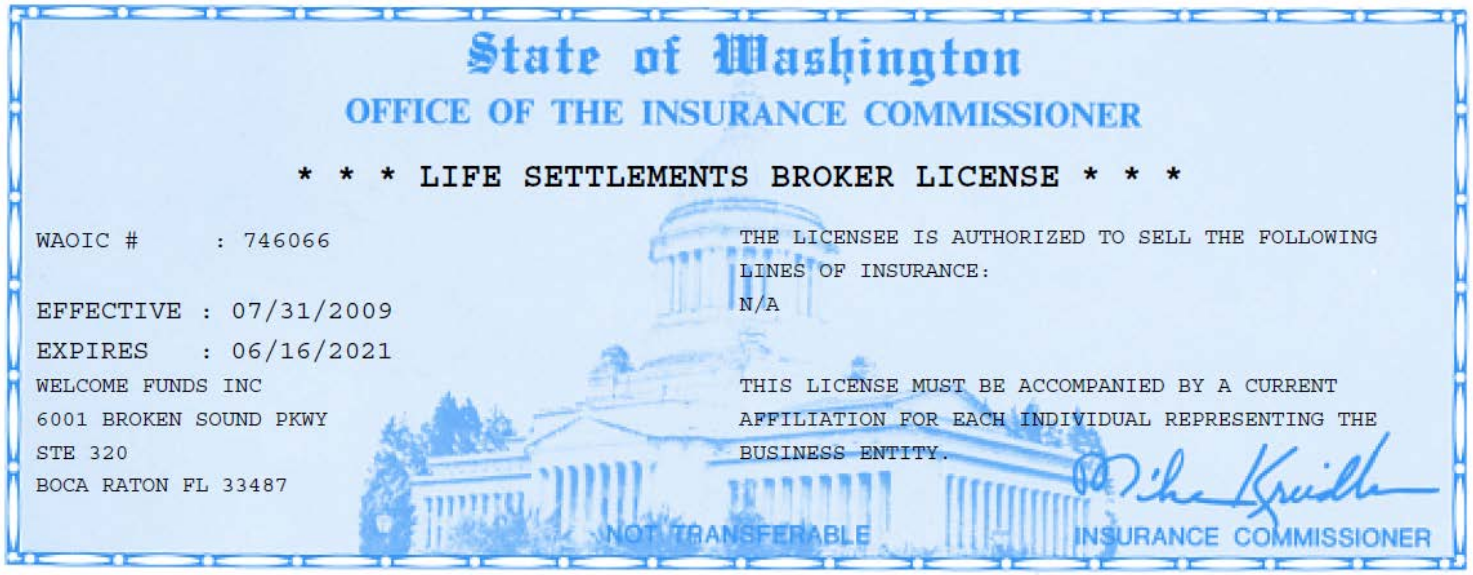
State of Washington

Life Settlements Broker License



State of Washington

OFFICE OF THE INSURANCE COMMISSIONER

* * * LIFE SETTLEMENTS BROKER LICENSE * * *

WAOIC # : 746066

EFFECTIVE : 07/31/2009

EXPIRES : 06/16/2021

WELCOME FUNDS INC
6001 BROKEN SOUND PKWY
STE 320
BOCA RATON FL 33487

THE LICENSEE IS AUTHORIZED TO SELL THE FOLLOWING LINES OF INSURANCE:
N/A

THIS LICENSE MUST BE ACCOMPANIED BY A CURRENT AFFILIATION FOR EACH INDIVIDUAL REPRESENTING THE BUSINESS ENTITY.

NOT TRANSFERABLE

INSURANCE COMMISSIONER

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

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

PRIMARY INSURED'S INFORMATION

PRIMARY INSURED NAME (FULL LEGAL NAME) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** | **TELEPHONE NUMBER**

CURRENT HOME ADDRESS | **CITY** | **STATE** | **ZIP CODE**

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 APPICABLE 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 APPICABLE 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**

☐ YES ☐ NO

POLICY LOAN AMOUNT (IF ANY) | **ACCUMULATED/CASH VALUE** (IF ANY) | **CASH SURRENDER VALUE** (IF ANY) | **CASH VALUE USED TO PAY PREMIUMS?**

☐ 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 OR YOUR HR DEPT. CONTACT

☐ 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 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

☐ 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 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:

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

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 ACKOWLEDGEMENTS

A. I/We represent that the information contained in this Evaluation Request for Sale of Existing Life Insurance is correct and accurate and acknowledge that WELCOME FUNDS INC may rely on such information as my/our broker for the potential sale of my/our life insurance policy. I/we also acknowledge that it is my/our responsibility to notify WELCOME FUNDS INC of any changes to this information, including any changes in health of the insured after this form has been submitted.

B. I/We understand that the market value of my/our life insurance policy is based in part on the health status and life expectancy of the insured. Current medical records for the insured are vital to obtain life expectancy assessments. These assessments are conducted by independent third-party life expectancy providers as required by the marketplace. WELCOME FUNDS INC is not responsible for the conclusions of these life expectancy providers and does not have the expertise to dispute those conclusions.

C. I/We acknowledge that WELCOME FUNDS INC is my/our broker who represents my/our best interests during the entire transaction process. I/We also understand and acknowledge that WELCOME FUNDS INC issues no guarantee that an offer will be secured for my/our policy.

D. I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial, insurance, medical and personal information gathered from this Evaluation Request for Sale of Existing Life Insurance, including but not limited to medical records, notes and lab reports pertaining to the insured's health, to the appropriate parties who have an identifiable need to review the information.

E. I/We acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my/our contract for the sale of my/our existing life insurance policy if my/our policy is purchased. In addition, I/we have been advised that I/we may obtain a copy, upon request, of any written agreement that I/we enter into regarding or relating to the sale of my/our existing life insurance policy(ies).

F. I/We acknowledge that I/we have been provided the following address/department to direct any consumer complaints that I/we may have: WELCOME FUNDS INC c/o Customer Complaints, to 4755 Technology Way – Suite 202, Boca Raton, FL 33431.

G. I/We understand and acknowledge that WELCOME FUNDS INC does not provide any advice as to whether or not to proceed with the sale of my/our life insurance policy and I/we are free to accept or decline any offer.

H. I/We understand and acknowledge that the policy owner is fully responsible for the timely payment of any and all premiums due for the policy that is the subject of this potential transaction, on the applicable due dates, up until change of ownership of the policy occurs, if a transaction is effectuated. I/We, not WELCOME FUNDS INC, assume sole responsibility if the policy lapses for failure to make timely payment of any and all premiums.

I. I/We would like to consider the following options in addition to a lump sum cash settlement offer (*subject to availability based on state residency, policy types and qualification requirements*):

☐ Retained Death Benefit (RDB) ☐ Cash Settlement with RDB ☐ Life Insurance Loan/Credit Line

☐ Expedited Bid Program (*may require additional disclosures*)

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

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

Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if not Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if applicable & if not Insured)	Printed Name	Date

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WASHINGTON -- NOTICE OF DISCLOSURE

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. **Welcome Funds Inc** & 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 **Welcome Funds Inc** & your referring advisor/broker, if any, is compensated.

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

3. The sale of your insurance policy may affect your eligibility to receive public assistance or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.

4. 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 &/or an attorney regarding these potential alternatives.

6. You have the right to terminate the life settlement contract within fifteen (15) days of the date it is executed by all parties & you have received the disclosures pursuant to Washington law. Rescission, if exercised, is effective only if both notice of rescission is given & all proceeds & any premiums, loans & loan interest have been paid on account of the provider within the rescission period. If the insured dies during the rescission period, then the contract shall be deemed rescinded, subject to repayment by you or your estate of all proceeds and any premiums, loans & loan interest to the provider.

7. Proceeds will be sent to you within three (3) business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred & the beneficiary has been designated in accordance with the terms of the life settlement contract. **Welcome Funds Inc** & your referring advisor/broker, if any, has no access to or control over provider funds set aside in escrow or trust.

8. You have the right to know the date by which the funds will be available & the transmitter of the funds.

9. Entering into a life settlement contract may 1) cause other rights or benefits, including conversion rights & waiver of premium benefits, which may exist under the policy or a certificate of a group life insurance policy to be forfeited; & 2) reduce the insured's ability to obtain future or additional life insurance coverage in the future because there is a limit to how much coverage insurers will issue on one (1) life. Assistance should be sought from a professional financial advisor.

10. Total compensation payable to **Welcome Funds Inc** & your referring advisor/broker, if any, shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds of your settlement are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the life settlement provider reduced by the total compensation as described above. Actual compensation shall be disclosed no later than the life settlement contract is signed by all parties.

[Additional Disclosures on Next Page]

11. All medical, financial or personal information solicited or obtained by a provider or **Welcome Funds Inc** about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement contract between you & the provider. If you are asked to provide this information, you will be asked to consent to this 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 policy 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 the provider or **Welcome Funds Inc** 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 no more frequently than 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. You have the right to know a) the affiliation, if any, between the provider & the issuer of the insurance policy to be settled; b) the name, address & telephone number of the provider; c) the affiliation or contractual arrangement, if any, between the provider & **Welcome Funds Inc**; & d) the name, business address & telephone number of the independent third-party escrow agent. In addition, you have the right to inspect or receive copies of the relevant escrow or trust agreements or documents.

14. **Welcome Funds Inc** 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. The commissioner may require delivery of a buyer's guide or a similar advisory package in the form prescribed by the commissioner to you during the solicitation process.

16. I/we confirm & acknowledge that **Welcome Funds Inc** has provided me/us with a brochure issued by the National Association of Insurance Commissioners (NAIC) titled, "Selling Your Life Insurance Policy: Understanding Life Settlements."

I/We acknowledge that I/we have read & understand the disclosures above (1-16).

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

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

TOLL-FREE: 877.227.4484
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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 _____

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

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WWW.WELCOMEFUNDS.COM

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

1. **Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, 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 authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. **Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **WELCOME FUNDS INC** including a) any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each, and b) 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, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and his or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
3. **Description of PHI Authorized for Disclosure and Purpose of Disclosure.** This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient to a) evaluate and/or underwrite my health status or life expectancy; and/or b) monitor, track or verify my health status in connection with any life insurance policy under which my life is insured that an Authorized Recipient, or any other person or entity, purchases. I hereby authorize the disclosure of my health information as described above. I understand the information disclosed may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, psychiatric care, mental health services, genetic testing, and/or treatment for alcohol and drug abuse.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.
5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
6. **Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** No 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 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)

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
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WWW.WELCOMEFUNDS.COM

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

1. **Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, 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 authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. **Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **WELCOME FUNDS INC** including a) any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each, and b) 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, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and his or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
3. **Description of PHI Authorized for Disclosure and Purpose of Disclosure.** This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient to a) evaluate and/or underwrite my health status or life expectancy; and/or b) monitor, track or verify my health status in connection with any life insurance policy under which my life is insured that an Authorized Recipient, or any other person or entity, purchases. I hereby authorize the disclosure of my health information as described above. I understand the information disclosed may include information relating to Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, psychiatric care, mental health services, genetic testing, and/or treatment for alcohol and drug abuse.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.
5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
6. **Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

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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** (Second Insured) _____ Printed Name _____ Date _____

Signature of **Legal Representative** of Second Insured (if any) _____ Printed Name _____ Date _____

Description of Legal Representative's **Authority** (if any): _____
(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)

Defining the Terms

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

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

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

Additional Questions to Consider

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

Consumer Alert

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

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:
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Selling Your Life Insurance Policy: Understanding Life Settlements

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.