



3 Mark Financial – Texas, Inc.  
 1600 Highway 6 Suite 400  
 Sugar Land, TX 77478  
 Toll Free: 866.588.2927  
 Telephone: 281.269.2300  
 Fax: 281.269.2347

**VIATICAL  
 SETTLEMENT APPLICATION**

**A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)**

Insured's Name	Date of Birth	Social Security Number
2 <sup>nd</sup> Insured's Name	Date of Birth	Social Security Number
Address		Phone Number
City	State	Zip Code

**B. LIFE INSURANCE INFORMATION**

Insurance Company	Policy Number	Face Amount
Date of Issue	Policy Type (WL, UL, SUL, Term, etc...)	Current Premium
Policy Owner	State of Residence	Beneficiary(s)
Is the policy owner a defendant in any suits or legal actions?		Yes _____ No _____
Has the policy owner ever declared bankruptcy?		Yes _____ No _____
Marital Status: Single/Never Married _____ Married _____ Widowed _____ Divorced _____		

**C. MEDICAL INFORMATION**

Insured Medical History _____	
2 <sup>nd</sup> Insured Medical History _____	
Primary Physician _____	Telephone Number _____
Specialist _____	Telephone Number _____

**For additional policy and/or physician information, please provide a supplementary page.**  
**For Agent Use:** If available, please include the following: 1) Current in force Illustration to maturity.  
 2) Current APS (if not within the last 90 days, please provide physician information in Section C).





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**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, the undersigned, authorize disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) as follows:

1.Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an “HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2.Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to 3 Mark Financial - Texas, Inc. and any of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an “Authorized Recipient”).

3.Protected Health Information 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 (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore, that 3 Mark Financial - Texas, Inc. brokers.

4.Expiration: This authorization shall remain valid until, and shall expire, one year after the date of my death.

5.Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization 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 HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that 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”). I further understand that, 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 redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

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.

\_\_\_\_\_  
 Signature of Individual (Viator)      Date

\_\_\_\_\_  
 Signature of Personal Representative of Individual      Date

\_\_\_\_\_  
 Print or Type Name of Individual (Viator)      Date

\_\_\_\_\_  
 Description of Personal Representative’s Authority:

\_\_\_\_\_  
 (Power of Attorney, Guardian ad Litem or similar status)



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**Life Insurance Information Release Form**

Life insurance policy number \_\_\_\_\_ issued by \_\_\_\_\_  
(Insurance Company), is owned by \_\_\_\_\_, and insured the life of  
\_\_\_\_\_.

I authorize the release to 3 Mark Financial - Texas, Inc. (3 Mark) or its designee, any or all information concerning the above policy.

I authorize 3 Mark to share this information with viatical settlement providers, brokerage general agents, and other parties, as required. The purpose of this sharing of information is to obtain quotes for viatical settlements, and / or life and health insurance policies.

\_\_\_\_\_  
Policy Owner (Viator) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Social Security Number



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**DISCLOSURE**

The owner of the life insurance policy to be viaticated, the viator, should be aware of the following:

1. That there are possible alternatives to viatical settlement contracts for persons who have a catastrophic or life-threatening illness including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy.
2. That proceeds of the viatical settlement could be taxable, and assistance should be sought from a personal tax advisor.
3. That viatical settlement proceeds could be subject to the claims of creditors.
4. That receipt of viatical settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements and advice should be obtained from the appropriate agencies.
5. That all viatical settlement contracts entered into in Florida must contain an unconditional rescission provision which allows the viator to rescind the contract within 15 days after the viator receives the viatical settlement proceeds, conditioned on the return of such proceeds.
6. The viator has the right to obtain the name, business address, and telephone number of the escrow agent and the viator may inspect or receive copies of the relevant escrow agreement.
7. The viator has the right to know, upon request, the identity of any person who will receive or has received a commission or other form of compensation from the viatical settlement provider with respect to their viatical settlement and the amount and terms of such compensation.

The viatical settlement provider company, not the viator, may compensate 3 Mark based on a formula that is a percentage of the face value of the life insurance policy. For example, compensation for a \$100,000 policy could be: 6% x \$100,000 (face value) = \$6,000.00.

\_\_\_\_\_  
**Signature of Insured**                      **Date**

\_\_\_\_\_  
**Signature of Policy Owner (Viator)**   **Date**

\_\_\_\_\_  
**Printed Name**                              **Date**

\_\_\_\_\_  
**Printed Name**                              **Date**

\_\_\_\_\_  
**Signature of Witness**                      **Date**

\_\_\_\_\_  
**Signature of Witness**                      **Date**

\_\_\_\_\_  
**Printed Name**                              **Date**

\_\_\_\_\_  
**Printed Name**                              **Date**