





## VIATICAL SETTLEMENT APPLICATION

### INSURED INFORMATION

First Insured Name		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number		Driver's License Number	Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what country?
Daytime Telephone Number		Evening Telephone Number	
Address			
City		State	Zip
Second Insured Name (if joint policy)		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number		Driver's License Number	Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what country?
Daytime Telephone Number ( )		Evening Telephone Number ( )	

### OWNER INFORMATION

Policy Owner		Social Security or Tax ID number(s)	
Complete Trust or Corporation name, and names of Trustee(s) or two officers			Date of Trust
Owner's Permanent Address			
City	State	Zip	
Beneficiary	Has the policy owner ever declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date discharged.		
Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what country?		Driver's License Number(s)	

### LIFE INSURANCE POLICY INFORMATION

Insurance Company		Policy Number	Issue Date
Face Amount \$	Total Policy Loan \$		Current Annual Premium \$
Next Premium Amount \$	Next Premium Due Date		Premium Payments <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly
Current Cash Surrender Value \$	Policy Type: Universal Life Whole Life Variable Life Term Survivorship Other (Please specify)		

Are there any liens against the policy?  
 Yes  No If yes, explain here. \_\_\_\_\_

If there is more than one owner, please attach an additional page. Include the full name of owner(s), along with their date of birth, driver's license number, social security or tax ID number, address and telephone number with area code. If more than one policy is being submitted, please attach an additional page. Include policy owner(s) and life insurance policy information as requested above.



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### MEDICAL INFORMATION

Please list any specific health conditions: \_\_\_\_\_  
 \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Has insured smoked in the past 12 months?  Yes  No       Cigarettes  Cigars  Cigarillos  Pipe

#### *First Insured*

Name of Primary Physician		Date/Reason Last Seen
Address		Telephone Number (    )
City	State	Zip
Name of Specialist		Date/Reason Last Seen
Address		Telephone Number (    )
City	State	Zip

#### *Second Insured (if joint policy)*

Name of Primary Physician		Date/Reason Last Seen
Address		Telephone Number (    )
City	State	Zip
Name of Specialist		Date/Reason Last Seen
Address		Telephone Number (    )
City	State	Zip

If there are any other physicians who have treated you in the last five years, please attach an additional page. Please include full name of physician(s), address, and telephone number with area code.



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### PERSONAL ACKNOWLEDGEMENT

I represent that the information contained in this application is correct and accurate. I represent that you may rely thereon and that I will immediately notify 3 Mark Financial Texas, Inc. ("3 Mark") of any changes in the information. I further give my consent to 3 Mark and its agents to release this application and all information gathered while processing it as necessary for the sole purpose of soliciting the purchase of my life insurance policy. I acknowledge that I am submitting this application for 3 Mark to evaluate the purchase of my life insurance policy. I acknowledge that 3 Mark is under no obligation to purchase my policy. I acknowledge that 3 Mark may contact me regarding the information contained in this application. I understand that some or all of the proceeds from a viatical settlement may be taxable. I understand that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that neither 3 Mark nor any of its affiliates or representatives have made any representations or provided any advice concerning the possible tax consequences or treatment of the proceeds of this transaction.

_____ Insured name	_____ Signature	_____ Date
_____ Second insured name	_____ Signature	_____ Date
_____ Policyowner name	_____ Signature	_____ Date
_____ Witness name	_____ Signature	_____ Date



# AUTHORIZATION

**Please include this authorization to release records and policy information with the application.**

I hereby authorize any Authorized Discloser identified below to provide 3 Mark Financial Texas, Inc. any and all information and/or records. Such information or records may include diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to 3 Mark the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential. I understand that the information will only be used by 3 Mark in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish 3 Mark with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser. Such revocation shall be completed by notifying such Authorized Discloser of my revocation of this Authorization in writing. I will deliver my revocation by mail or personal delivery at such address designated by such Authorized Discloser. I understand that any revocation of this Authorization shall not apply to the extent that:

- (i) The Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation.
- (ii) If this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

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, any of my medical information disclosed by any Authorized Discloser to 3 Mark may be redisclosed by 3 Mark and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below. I certify that all information contained in this Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photo copy, facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

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## AUTHORIZED DISCLOSERS:

Insured name	Insured signature	Date
Date of birth	Social security number	
Witness name	Witness signature	Date
Owner name (if other than insured)	Owner signature (if other than insured)	Date
Witness name	Witness signature	Date

**3 Mark Financial Texas, Inc.**  
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[www.3mark.com](http://www.3mark.com)



# DISCLOSURE

Insured's Name: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## NOTICE OF DISCLOSURE

1. There may be alternatives to a settlement contract for which you may be eligible. Examples of these alternatives may include, but are not limited to, accelerated benefits, loans secured by the policy, and surrender of the policy for cash value offered by the issuer of the policy. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. We encourage you to contact the issuer of your policy to discuss these other benefits.
2. Some or all of the proceeds of your settlement may be taxable under federal income tax and/or state franchise and income tax laws. 3 Mark Financial Texas, Inc. ("3 Mark") strongly urges you to consult your own attorney or tax advisor concerning this transaction.
3. Some or all of your settlement proceeds may adversely affect your eligibility for some government benefits or entitlements. 3 Mark suggests that you obtain advice on such effects from the correct government agencies.
4. Proceeds from your settlement may not be exempt from claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
5. If your policy contains a provision for double or additional indemnity for accidental death, or contains riders or other provisions insuring the lives of a spouse, dependents or others, there may be a loss of coverage. We urge you to contact the issuer of your life insurance policy for information on these provisions.
6. Entering into a settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends. Entering into a settlement may cause you to forfeit other rights or benefits. These rights or benefits may include conversion rights and waiver of premium benefits that may exist under the policy.
7. All medical, financial or personal information solicited or obtained by 3 Mark about you may be disclosed as necessary to effect the settlement between you and 3 Mark. Such information may include your identity or the identity of family members, a spouse or significant other. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be presented to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two (2) years.
8. You may be contacted by 3 Mark or its authorized representative to determine your health status. This contact will be limited to no more often than once every three (3) months.
9. Funds will be sent to you immediately after 3 Mark has received the insurer's or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated.
10. You have the right to rescind your settlement contract. You may rescind the contract no later than fifteen (15) days after receipt of the proceeds. Or, you may rescind the contract no later than thirty (30) days after the date that the contract is executed by all parties, whichever period of time is longer. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded.
11. There are potential consequences of your settlement contract. 3 Mark encourages you to consult with an attorney, accountant, financial planning advisor, insurer, tax advisor, or social services agency about these potential consequences.

Insured's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insured's Typed or Printed Name: \_\_\_\_\_

Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Owner's Typed or Printed Name: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Typed or Printed Name: \_\_\_\_\_