



VIATICAL SETTLEMENT APPLICATION

Our Company waives the deemer provisions contained in Oklahoma Statute 36 O. S. 3610.B.

CHECKLIST FOR APPLICATION PACKAGE

- Application filled out completely, signed, dated and witnessed
HIPAA compliant release ("Authorization") signed, dated and witnessed
Notice of Disclosure ("Disclosure") signed, dated and witnessed
Copy of the insurance policy if available, or a copy of the face page
In force illustrations showing zero cash value at maturity
If Universal Life policy, show minimum premium payments
If Term policy, submit a current illustration and a conversion illustration to a permanent policy showing minimum premium payments
If Whole Life policy, run a vanishing premium illustration
Medical records for the last five years including family history
If policyowner has ever been bankrupt, include a copy of the bankruptcy discharge
If policyowner has ever been divorced, include a copy of the divorce decree

In some cases the following may be requested: updated medical records, doctors' notes, test results, or alternate illustrations.

Representing Agent (print name)

Broker/Dealer

Address

Phone

Fax

E-Mail

Is the representing agent the agent of record? [] Yes [] No

Agent signature

Date

REMINDER: ALL NEW CASES MUST HAVE THIS DOCUMENT ATTACHED AND MUST BE SENT TO OUR PROCESSING CENTER.

William H. Propper, III
c/o 3 Mark Financial Texas, Inc.
1600 Highway 6 Suite 400 Sugar Land, Texas 77478
Tel 281.269.2300 Fax 281.269.2347 Toll Free 800.533.6275
www.3mark.com



VIATICAL SETTLEMENT APPLICATION

INSURED INFORMATION

| | | | |
|---------------------------------------|-------------------------|--|--|
| First Insured Name | | Date of Birth | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| First Insured 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 |
| Second Insured Social Security No. | 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, 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: _____

If there are multiple owners, please attach an additional page including full name of owner(s), 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 including policyowner(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: Cigarettes Cigars Cigarillos Pipe In the past 12 months? Yes No

First Insured

| | | |
|------------------------------|-------|-----------------------------------|
| Name of Primary Physician | | Date/Reason Last Seen |
| Address | | Telephone Number (with area code) |
| City | State | Zip |
| Name of Specialist Physician | | Date/Reason Last Seen |
| Address | | Telephone Number (with area code) |
| City | State | Zip |

Second Insured (if joint policy)

| | | |
|------------------------------|-------|-----------------------------------|
| Name of Primary Physician | | Date/Reason Last Seen |
| Address | | Telephone Number (with area code) |
| City | State | Zip |
| Name of Specialist Physician | | Date/Reason Last Seen |
| Address | | Telephone Number (with area code) |
| City | State | Zip |

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

PERSONAL ACKNOWLEDGEMENT

I represent and warrant that the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify William H. Propper, III c/o 3 Mark Financial Texas, Inc. ("3 Mark") of any changes in the information. I further give my consent to William H. Propper, III c/o 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 William H. Propper, III c/o 3 Mark to evaluate the purchase of my life insurance policy and that William H. Propper, III c/o 3 Mark is under no obligation to purchase my policy. I acknowledge I may be contacted by William H. Propper, III c/o 3 Mark regarding the information contained in this application. I understand that some or all of the proceeds from a viatical settlement may be taxable and that I am encouraged to consult with an attorney or tax advisor concerning this transaction. I also acknowledge that neither William H. Propper, III, 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 this application.

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an "Authorized Discloser") to provide William H. Propper, III c/o 3 Mark Financial Texas, Inc. ("3 Mark") and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("3 Mark"), any and all information and/or records as to 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 William H. Propper, III c/o 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 and will only be used by William H. Propper, III c/o 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 William H. Propper, III c/o 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 by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, 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 or (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 William H. Propper, III c/o 3 Mark may be redisclosed by William H. Propper, III c/o 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 and 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 photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid for a period no longer than 24 months.

AUTHORIZED DISCLOSERS:

| | | |
|---------------------------------------|--|------|
| name of insured | signature of insured | date |
| date of birth | social security number | |
| name of witness | signature of witness | date |
| name of owner (if other than insured) | signature of owner (if other than insured) | date |
| name of witness | signature of witness | date |

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DISCLOSURE

Insured's Name: _____ Social Security: _____ - _____ - _____

NOTICE OF DISCLOSURE

1. There may be alternatives to a viatical settlement contract including, but 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 for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance carrier and/or policy. You are encouraged to contact the issuer of your policy to discuss these other benefits.
2. Some or all of the proceeds of your viatical settlement may be taxable under federal income tax and/or state franchise and income tax laws. William H. Propper, III c/o 3 Mark Financial Texas, Inc. ("3 Mark") strongly urges you to consult your own attorney or tax advisor concerning this transaction. William H. Propper, III c/o 3 Mark makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of your viatical settlement proceeds may adversely affect your eligibility for social security income, public assistance, public medical services including Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Proceeds from a viatical settlement may not be exempt from claims of creditors, personal representatives, trustees in bankruptcy and receivers in state or federal court.
5. With respect to policies containing provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the owner prior to entering into the viatical settlement agreement, or to such other beneficiary, other than the viatical settlement provider, as the owner may thereafter designate, or in the absence of a designation, to the estate of the owner.
6. Entering into a viatical settlement will have an effect on payment of premiums and disposition of proceeds, cash values and dividends and may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy to be forfeited by you.
7. All medical, financial or personal information solicited or obtained by William H. Propper, III c/o 3 Mark 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 settlement between you and William H. Propper, III c/o 3 Mark. If the insured is asked to provide this information, the insured 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. The insured may be asked to renew his or her permission to share information every two years.
8. The insured may be contacted by William H. Propper, III c/o 3 Mark for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months.
9. Funds will be sent to you within three (3) business days after William H. Propper, III c/o 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 the beneficiary has been designated.
10. You have the right to rescind a viatical settlement contract for a period of thirty (30) calendar days from the date of the contract, or fifteen (15) calendar days after your receipt of the proceeds, whichever is less. If the insured dies during the rescission period, the settlement contract shall be deemed rescinded.
11. You are encouraged to contact an attorney, accountant, financial planning advisor, insurer, tax advisor or social services agency regarding potential consequences resulting from entering into a viatical settlement.

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: _____

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