1719 Route 10
Suite 233
Parsippany , NJ 07054

PRIMARY CONTACT			
Name of the person completing questionairre		Email	
Primary Phone Number		Best Time to Call Morning ☐ Afternoon ☐ Evening ☐	
POLICY DETAILS			
Insurance company		Policy number	
Death Benefit	Policy Loan	Issue Date	
Type of Policy (Circle One) Term(Convertible) Universal Life Whole Life Survivorship Univer. Life Variable Univer. Life			
Total amount of Death Benefit on the Insured			
POLICYOWNER(S) INFORMATION			
Name of Policyowner(s)			
Name of Contact(s) (if corporate owned)			
Name of Trustee(s) (if trust owned)			
Address (for the past 5 years)			
Marital Status Single/Married/Divorced/Widowed	Are you a US Citizen? YES NO If no, specify country of citizenship		
Social Security or Tax ID Number		Primary Phone Number	
INSURED INFORMATION			
Name of Insured	Date of Birth	Sex Male/Female	Marital Status Single/Married/Divorced/Widowed
Height / Weight	Are you a US Citizen? YES NO If no, specify country of citizenship		
Social Security or Tax ID Number		Primary Phone Number	
Address (for the past 5 years)			

FAMILY HISTORY

			IF LIVING	IF DECEASED	
	AGE	**SEX**	**State of Health**	**AGE**	**Cause of Death (include date of death)**
Spouse		Male / Female			
Mother		Male / Female			
Father		Male / Female			
Sibling		Male / Female			
Sibling		Male / Female			
Sibling		Male / Female			

ACTIVITIES OF DAILY LIVING			
Do you need assistance to perform any of the following tasks?			
1	Dressing		YES NO
2	Bathing or Showering		YES NO
3	Ambulation from chair to bed or indoors to outdoors		YES NO
4	Using the lavatory		YES NO
5	Preparing food or eating		YES NO
6	Continence Issues		YES NO
LIFESTYLE AND ACTIVITY INFORMATION			
Are you curretnly employed?			YES NO
1	If "yes", please list occupation and hours worked per week.		
Are you involved in clubs, organizations, hobbies, travel or volunteer?			YES NO
1	If "yes", indicate frequency and type.		
Have you ever used tobacco in any form?			YES NO
1	If "yes", what kind of tobacco do you use?	TYPE	DATE OF LAST USE
2	Frequency that you use them:	Daily Weekly Monthly Socially	
3	Age that you begin using:		
Do you currently drink alcohol?			YES NO
1	What type of alcohol do you drink?		
2	How many drinks per week do you consume		
Have you had any falls, driving offenses, or family issues related to use?			YES NO
Do you currently exercise?			YES NO
1	If "yes", please list the type of exercise and how often.		
Have you had any falls in the last 2 years?			YES NO
1	If "yes" what was the cause and were injuries sustained?		
Do you have any problems balancing or walking?			YES NO
Do you use a walker or cane?			YES NO
Do you use a wheelchair occasionally?			YES NO
Are you wheelchair bound?			YES NO
Are you bed bound?			YES NO
Are you legally blind?			YES NO
Are you independent with grocery shopping?			YES NO
Are yo independent with your finances?			YES NO
Do you operate a motor vehicle on a regular basis?			YES NO
Has your doctor or family advised you to refrain from driving?			YES NO
Do you have a valid drivers license?			YES NO
1	If "yes", please list state and number		
Have you had a driver's license restricted, revoked or been convicted of 3 or more moving violations in the last 5 years?			YES NO
Do you live in an Assisted Living or Nursing Home?			YES NO
1	If answered "yes" indicate dates of residency.		
Do you live in a Skilled Nursing Facility?			YES NO
1	If answered "yes" indicate dates of residency.		
Are you under palliative care therapy?			YES NO
1	If answered "yes" indicate date began and reason.		

Are you currently receiving Hospice care?	YES	NO
1 If answered "yes" indicate date hospice started, facility or home		
CARDIOVASCULAR		
Please list the following, if known		
Have you ever been diagnosed with heart disease?	YES	NO
Have you been diagnosed with coronary artery disease?	YES	NO
Have you had coronary bypass surgery?	YES	NO
1 If so, date(s) of surgery?		
2 How many vessels were bypassed?		
Have you had angioplasty or stents?	YES	NO
1 If so, date(s) of surgery?		
2 Number of stents use for each surgery		
Have you had a valve replacement or repair?	YES	NO
Have you had a heart attack?	YES	NO
1 If so, please list the date(s) of heart attack.		
Do you have a pacemaker or implanted defibrillator?	YES	NO
Do you have a history of congestive heart failure?	YES	NO
Do you have a history of cardiomyopathy?	YES	NO
OTHER COMMENTS		
NEUROLOGICAL		
Have you had a stroke or TIA	YES	NO
1 If "yes", which did you have?		
2 What were the approximate date(s) of the episodes?		
3 Do you have any effects as a result?		
4 If "yes", what type of effect did it have?		
OTHER COMMENTS		
DIABETES		
Have you been diagnosed with diabetes?	YES	NO
Type of diabetes?		
How old were you when you were diagnosed?		
Do you take insulin?	YES	NO
Last A1c reading (if known)		
Is you blood sugar level under control	YES	NO
Do you have any side effects	YES	NO
1 If "yes" what type of effect?		
Are you following treatment(diet, medication, regular testing)	YES	NO
OTHER COMMENTS		
CANCER		
What type of cancer and if so, what stage were you diagnosed with?		
1 Date of Diagnosis		
What was the primary location of the cancer?		
Has the cancer spread to other areas?	YES	NO
1 If so, where?		
Did you have surgery?	YES	NO
1 List the dates of the surgery(ies)		
Did you undergo chemotherapy?	YES	NO
1 List the date of your last treatment		

Did you undergo radiation treatment?	YES	NO
1 List the date of your last treatment		
What was the last date of any treatment?		
Are you currently in remission?	YES	NO
Have you had any reoccurrence?	YES	NO
OTHER COMMENTS		
RESPIRATORY FUNCTION		
Have you been diagnosed with COPD?	YES	NO
1 Date of Diagnosis		
Have you been diagnosed with emphysema?	YES	NO
1 If so, date of diagnosis		
Do you suffer shortness of breath?	YES	NO
1 If so, when?		
Do you suffer shortness of breath at rest?	YES	NO
How many flights of stairs can you climb without being short of breath		
OTHER COMMENTS		
NEPHROLOGY		
Do you have a history of kidney disease?	YES	NO
What stage if kidney disease?		
Are you currently on dialysis?	YES	NO
OTHER COMMENTS		
NEUROLOGY		
Have you been diagnosed with Dementia?	YES	NO
Have you been diagnosed with Alzheimer's?	YES	NO
1 If so, please provide the date of diagnosis?		
2 Date of last Mini-Mental State Examination MMSE if known		
3 Results of last Mini-Mental State Examination MMSE if known		
4 Do you get confused about where you are, what date or day of the week?	YES	NO
5 Do forget the names of your spouse or significant other?	YES	NO
6 Do you wander?	YES	NO
7 Do you feel agitated?	YES	NO
8 Do you have a full time nurse?	YES	NO
Have you been diagnosed with Multiple Sclerosis?	YES	NO
1 If so, please provide the date of diagnosis?		
Have you been diagnosed with ALS(Amyotrophic lateral sclerosis)?	YES	NO
1 If so, please provide the date of diagnosis?		
Have you been diagnosed with Parkinson's?	YES	NO
1 If so, please provide the date of diagnosis?		
OTHER COMMENTS		
HIV, AIDS		
Have you been diagnosed with HIV or AIDS or ARC?	YES	NO
1 If so, what was your specific diagnosis?		
OTHER COMMENTS		
MISCELLANEOUS		
Have you been hospitalized recently?	YES	NO
1 Date of hospitalization.		
2 Reason for hospitalization?		
Have you been hospitalized in the last 5 years for mental health or substance abuse issues?	YES	NO

Have you recently been diagnosed with a mental illness?		YES NO
1	If so, please describe the diagnosis	
2	Do you suffer from anxiety or depression?	
Do you use any recreational drugs		YES NO
1	Frequency that you use them:	
2	Have you had any falls, driving offenses, or family issues related to use?	YES NO
Have you recently had symptoms of chest pain, leg pain, shortness of breath or general weakness		YES NO
1	If so, please describe	
Do you have any non-healing wounds?		YES NO
Have you experienced significant unintentional weight loss?		YES NO
Do you currently use oxygen?		YES NO
Do you have a history of bone or joint abnormality or problems balancing or an abnormal gait?		YES NO
Do you have any blood disorder? (Anemia, leukemia etc.)		YES NO
1	If so, please describe	
Have you been diagnosed or treated for any other disease or disorder not listed?		YES NO
1	If so, please describe	
OTHER COMMENTS		

SURGERIES

Have you had any surgical procedures in the last 5 years?			YES NO
1	If yes please list the procedure, the reason for and the date of the procedure.		
	Surgery	**Reason for Procedure**	**Date**
1			
2			
3			
4			
5			
6			

MEDICATION

Are you taking any prescribed medication?			YES NO
1	If yes please list the medication, the dosage and frequency of usage.		
2	Do you take your medication as prescribed?		YES NO
	Medication Name	**Dosage**	**Frequency (X a day)**
1			
2			
3			
4			
5			
6			
7			

PHYSICIAN INFORMATION

	Specialty	**Name of Physician**	**Date of Last Visit**
1			
2			
3			
4			
5			
6			

Additional Information. (Please provide question number with additional information)	
Question	**Details**

I hereby acknowledge that Life Policy Traders, Inc. ("LPT") may provide this questionnaire and any and all information provided herein, including my personal and/or health related information, to LPT's affiliates, as well as non-affiliated contracted parties, for the purpose of evaluating and qualifying for a life settlement, one or more life insurance policies under which my life is insured.

I hereby represent and warrant that any and all information provided by me in this questionnaire is true and correct as of the date hereof. I hereby affirm my understanding that LPT, any of its affiliates, and/or any of their respective directors, officers, employees, agents, independent contractors, service providers or other authorized representatives (each, an "Indemnified Person") will be relying on the statements and responses made by me in this questionnaire and I agree to hold each Indemnified Person harmless and agree to indemnify each Indemnified Person from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

I UNDERSTAND THAT IT IS A CRIME TO KNOWINGLY PRESENT FALSE, INACCURATE, INCOMPLETE OR MISLEADING INFORMATION TO, OR CONCEAL INFORMATION RELATED TO AN APPLICATION FOR INSURANCE OR FOR A LIFE SETTLEMENT FROM AN INSURANCE COMPANY OR A LIFE SETTLEMENT PROVIDER FOR THE PURPOSE OF DEFRAUDING SUCH COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF BENEFITS AND CIVIL DAMAGES. I UNDERSTAND THAT LPT HAS ANTI-FRAUD INITIATIVES IN PLACE DESIGNED TO DETECT AND PREVENT FRAUD, AND MAY REPORT CASES OF SUSPECTED FRAUD TO THE APPROPRIATE LEGAL AND REGULATORY AUTHORITIES OR INSURANCE COMPANIES.

Name of Insured | Signature of Insured | Date

Authorization (Please sign and include this authorization to release medical and policy information)

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefits manager, hospital, clinic and/or any other healthcare provider identified below (each, an "Authorized Discloser") to provide Life Policy Traders, Inc.("LPT") and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("LPT"), 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 LPT 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 LPT in connection with the evaluation and qualification for a life settlement or other mortality-based product. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

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

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser or LPT 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 healthcare provider, healthcare 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 LPT may be disclosed to someone else by LPT 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 photocopy or 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.

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

This authorization may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.