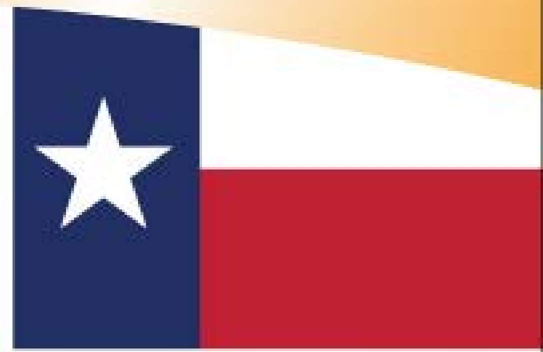
It's about *Choice*



WELCOME FUNDS

Life Settlements. Simplified.®

TEXAS
STATE APPLICATION

1.877.227.4484 welcomefunds.com

WELCOME FUNDS

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

State of Texas

Life Settlement Broker License

Life Settlement Broker

WELCOME FUNDS, INC.
4755 TECHNOLOGY WAY STE 202
BOCA RATON, FL 33431-3338

is authorized to transact business as described above

License No: 1906250 Issue Date: 04-01-2014 Expiration Date: 10-24-2024

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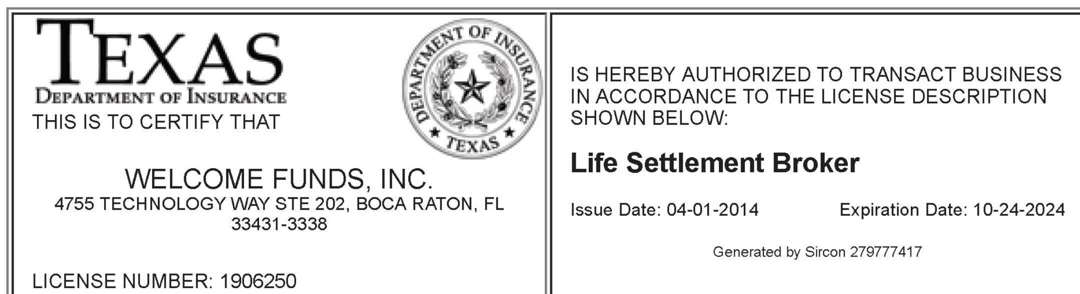

TEXAS
DEPARTMENT OF INSURANCE
THIS IS TO CERTIFY THAT

WELCOME FUNDS, INC.
4755 TECHNOLOGY WAY STE 202, BOCA RATON, FL 33431-3338

LICENSE NUMBER: 1906250

IS HEREBY AUTHORIZED TO TRANSACT BUSINESS IN ACCORDANCE TO THE LICENSE DESCRIPTION SHOWN BELOW:

Life Settlement Broker

Issue Date: 04-01-2014 Expiration Date: 10-24-2024

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LETTER FROM THE PRESIDENT

Dear Policy Owner/Insured:

Thank you for choosing WELCOME FUNDS INC to help you determine and identify the merits and value of selling your policy. We understand that the process can be intimidating and overwhelming and it is our job to not only maximize the sales value of your policy(ies) in the secondary market, but also to provide a seamless, transparent and fully informed experience. Please complete our Evaluation Request for Sale of Existing Life Insurance and sign the appropriate pages.

As your designated broker who represents your best interests and follows your instructions, WELCOME FUNDS INC incurs the necessary, required and related costs to facilitate the potential sale of your policy related to the following services:

- Evaluation Form assessment.
- Medical underwriting and insurance verifications.
- Obtaining and forwarding independent third party life expectancy reports.
- Submission to multiple authorized and/or registered buyers of life insurance policies.
- Best execution negotiation to maximize fair market value of the sale of your policy.
- Closing services including contract review and assistance with contingency requirements of buyers of life insurance policies.

Please read the Notice of Disclosure and the Broker Authorization and Services Agreement carefully and sign accordingly. These pages represent the first step in explaining your rights and obligations associated with the process. With that said, you are under no obligation to accept any contingent offers secured by WELCOME FUNDS INC. Furthermore, we have attached a brief brochure issued to provide an unbiased, independent description of selling policies in the secondary market. Please read the brochure as well.

Please be advised that the personal information acquired shall only be shared with individuals and entities with an identifiable need to help determine the market value of your policy, including but not limited to life expectancy underwriters and potential buyers of your policy. All parties involved in the analysis, evaluation, underwriting and contingent pricing for transactions are required to maintain strict privacy and confidentiality safeguards pursuant to applicable state and federal regulations.

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
President

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ADDITIONAL DOCUMENT CHECKLIST

Please include the following documents, if available, with your Evaluation Request to significantly decrease the time necessary to facilitate the potential sale of your policy. If you cannot provide the items below, then Welcome Funds Inc will attempt to obtain items A & B with the authority granted from the signed authorizations contained herein. Items C through H must be obtained through your own efforts.

☐ A. Current In Force Illustrations for Each Policy (please confirm desired/required illustrations with Welcome Funds Inc).

☐ B. Medical Records for the Last Five (5) Years for Each Insured.

☐ C. Photocopy of Two Forms of Identification (ie. Drivers License, SS Card, Passport etc...) for Each Insured & Policy Owner.

☐ D. Photocopy of Applicable Insurance Policy/Policies (including applications for insurance).

☐ E. Photocopy of Trust or Corporate Formation Documents (if applicable).

☐ F. Photocopy of Divorce Decree of Insured & Policy Owner (if applicable).

☐ G. Photocopy of Bankruptcy Discharge of Insured & Policy Owner (if applicable).

☐ H. Photocopy of All Premium Finance Documents (if applicable).

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PRIVACY ACKNOWLEDGEMENT & AUTHORIZATION

The following section, in part, contained in the Life Settlements Act of Texas addresses the way the insured's personally identifiable information, including without limitation, his or her financial, medical and insurance related information, is permitted to be disclosed. With the insured's required signature, the insured is acknowledging the law as indicated below and authorizing his or her consent to such disclosure.

Section 1111A.006

(d) Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance agent, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, may not disclose the identity of an insured, or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information, to any other person unless the disclosure is:

(1) necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;
(2) necessary to effectuate the sale of a life settlement contract, or interests in the contract, as an investment, provided that the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure;
(3) Provided in response to an investigation or examination by the commissioner or another governmental officer or agency under Texas law, Section 1111A.018, "Fraud Prevention and Control;"
(4) a term or condition of the transfer of a policy by one provider to another licensed provider, in which case the receiving provider shall comply with the confidentiality requirements of this subsection;
(5) necessary to allow the provider or broker or the provider's or broker's authorized representative to make contact for the purpose of determining health status provided that in this subdivision, authorized representative does not include a person who has or may have a financial interest in the contract other than a provider, licensed broker, financing entity, related provider trust or special purpose entity and that the provider or broker requires the authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or
(6) required to purchase stop loss coverage; or
(7) otherwise permitted by regulation promulgated by the commissioner or another governmental officer or agency under Texas law, Section 1111A.018, "Fraud Prevention and Control."

In addition to the acknowledgement and authorization above, with the signature below, each undersigned is allowing his or her personally identifiable information, including without limitation, his or her financial, medical and insurance related information, to be transmitted electronically, via e-mail or through a password protected and secure website, to the appropriate parties, permitted by Texas law, who have an identifiable need to facilitate the sale of the life insurance policy or policies.

Acknowledged & Authorized By:

______________________	______________________	__________
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

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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

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.

The information provided below shall be used to evaluate, underwrite and generate conditional offers for the sale of your life insurance policy.

PRIMARY INSURED'S PERSONAL INFORMATION

PRIMARY INSURED NAME (AS LISTED WITH LIFE INSURANCE CARRIER) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER**

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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**

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

SECONDARY INSURED'S PERSONAL INFORMATION (IF APPLICABLE – SURVIVORSHIP ONLY)

SECONDARY INSURED NAME (AS LISTED WITH LIFE INSURANCE CARRIER) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER**

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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**

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 if there is additional medical information, then please attach a separate sheet with complete details.

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LIFE INSURANCE POLICY INFORMATION

LIFE INSURANCE COMPANY | POLICY NUMBER | ISSUE DATE

FACE AMOUNT | TOTAL POLICY LOAN AMOUNT | CASH SURRENDER VALUE

☐ 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

☐ 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 THE NAMES AND RELATIONSHIP OF ALL PRIMARY BENEFICIARIES OF THE POLICY (IF IT IS A TRUST, PROVIDE NAME AND ADDRESS OF TRUSTEE)

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

EXACT NAME OF POLICY OWNER (INDIVIDUAL / CORP. / TRUST - AS LISTED WITH LIFE INSURANCE CARRIER) | **SOCIAL SECURITY OR TAX ID NUMBER**

POLICY OWNER ADDRESS (ADDRESS / STATE OF DOMICILE OF INDIVIDUAL / CORP. / TRUST) | **TELEPHONE NUMBER**

CITY | STATE | ZIP CODE

EXACT NAME OF CORPORATE OFFICER(S) / TRUSTEE(S) (IF CORPORATE / TRUST OWNED POLICY) | **DATE OF INCORPORATION / TRUST**

IF THERE ARE MULTIPLE POLICY OWNERS, THEN PLEASE LIST ALL NAMES AND STATES OF RESIDENCE

IF THERE ARE MULTIPLE 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 POLICY OWNER EVER DECLARED BANKRUPTCY? | IF SO, HAS IT BEEN DISCHARGED? | WHEN WAS IT DISCHARGED?

For multiple policies, please photocopy this page, complete the above information and sign new insurance authorizations for each policy.

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ADDITIONAL INFORMATION

I. PLEASE DESCRIBE REASONS FOR CONSIDERING THE SALE OF POLICY(IES), CHECK ALL THAT APPLY:

- ☐ No longer require or want to pay for the life coverage
- ☐ Health & living expenses are a financial burden
- ☐ Interested in learning market value of policy
- ☐ Planning to lapse, cancel, or surrender the policy
- ☐ Considering a 1035 Exchange or replacement policy
- ☐ Cash liquidity preferred due to current financial situation
- ☐ Other or provide further details: ____________________

All Policy Owner(s) and Insured(s) please sign at the bottom of the page, regardless of whether you complete all of the financial information below.

Please be advised that any Policy Owner(s) and/or Insured(s) who declines to provide full and complete financial data acknowledges and accepts responsibility that such lack of data will impede Welcome Funds Inc's ability to provide recommendations it deems suitable, based on personal and specific financial needs, conditions and situations.

☐ **Check here if you choose NOT to complete some or all of the requested financial information below (and sign below).**

II. INVESTMENT PROFILE (PLEASE USE COMBINED FIGURES FOR JOINT ACCOUNTS):

INVESTMENT OBJECTIVES: *(check all that apply)* ☐ Capital Preservation ☐ Income ☐ Capital Appreciation/Growth ☐ Speculation

POLICY OWNER'S TAX BRACKET: ☐ 10% ☐ 15% ☐ 25% ☐ 28% ☐ 33% ☐ 35%

POLICY OWNER'S NET WORTH: ☐ $0 - $49,999 ☐ $50,000 - $99,999 ☐ $100,000 - $199,999 ☐ $200,000 -$499,999 ☐ $500,000 - $999,999 ☐ $1,000,000 - $2,499,999 ☐ $2,500,000 and up

ESTIMATED INSURABLE CAPACITY FOR INSURED(S): $____________________

TOTAL AMOUNT OF IN-FORCE LIFE INSURANCE COVERING INSURED(S): $____________________

III. PLEASE CERTIFY THE CURRENT ACCREDITED INVESTOR STATUS OF THE POLICY OWNER:

THE POLICY OWNER IS CONSIDERED AN ACCREDITED INVESTOR: ☐ YES ☐ NO

(Refer to the definitions below to answer the above question and if "yes," then please check the appropriate description)

INDIVIDUALS:

_________ 1. An individual that has a net worth or joint net worth, with the individual's spouse, in excess of $1,000,000. "Net worth" for these purposes is defined as the value of total assets at fair market value, including but not limited to non-primary residence home (the value of the primary residence, as of July, 2010, is excluded), home furnishings and automobiles, less total liabilities; or

_________ 2. An individual that (i) had income (exclusive of any income attributable to the individual's spouse) of more than $200,000 for each of the past two years or joint income with the individual's spouse in excess of $300,000 in each of those years, and (ii) reasonably expects to reach the same individual income level, or the same joint income level, as the case may be, in the current year; or

ENTITIES:

_________ 3. A corporation, partnership, limited liability company, Massachusetts or similar business trust or tax-exempt organization as defined in Section 501(c)(3) of the Code, that (i) has total assets in excess of $5,000,000, and (ii) was not formed for the specific purpose of investing in the life insurance policy and then selling it; or

_________ 4. A revocable trust which may be amended or revoked at any time by the grantors thereof, and of which all of the grantors are accredited investors under either (1) or (2) above; or

_________ 5. A trust (i) that has total assets in excess of $5,000,000, (ii) that was not formed for the specific purpose of acquiring the life insurance policy and then selling it, and (iii) whereby the investment decisions are directed by a person who has such knowledge and experience in business and financial matters and who can evaluate the merits and risks of its investments; or

_________ 6. A trust for which a bank or savings and loan association is acting as fiduciary in directing investment decisions; or

_________ 7. An entity whose equity owners are each "accredited investors" i.e., persons meeting the requirements set forth in either of (1) or (2) above.

Verified and Confirmed By:

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

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PERSONAL ACKNOWLEDGEMENTS

I. Do you have a referring advisor/broker authorized, on your behalf, to a) represent your interests regarding this Evaluation Request & potential transaction; & b) to accept offers, if any, for the sale of your existing life insurance policy?

☐ Yes ☐ No

If Yes, then please provide the name(s) of such advisor(s)/broker(s) below:

______________________ Name of **Referring Advisor /Broker #1**

______________________ Name of **Referring Advisor/Broker #2** (if applicable)

II. Have you signed a Power of Attorney (POA) granting a legal representative to act on your behalf or do you have a Guardian ad Litem or similar legal representative acting on your 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) attach the applicable legal documents to this Evaluation Request; 2) have the legal representative of the insured sign the "Authorization for Disclosure of Protected Health Information" forms for the primary and secondary insured as applicable; 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)

III. How did you learn about the option to sell your insurance policy?

☐ Through my/our own knowledge and/or research and asked to receive this Evaluation Request.

☐ Through my/our referring advisor/broker.

IV. Was this insurance policy premium financed?

☐ Yes ☐ No

If yes, then please 1) attach all finance documents, including contracts, trusts and/or corporate documents etc…in order to evaluate and determine the validity and legality of this potential transaction for insurable interest; 2) provide the name of the financing company: ______________________.

Name of **Financing Company** (if applicable)

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, including but not limited to the Personal Acknowledgements above. I/we will immediately notify WELCOME FUNDS INC of any changes.

I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial and insurance 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 facilitate the sale of my/our life insurance policy.

I/We further acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my contract for the sale of my existing life insurance policy if my/our life insurance 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 life insurance policy(ies).

Acknowledged By:

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

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WELCOME FUNDS

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NOTICE OF DISCLOSURE (PAGE 1 OF 2)

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

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1. There are possible alternatives to life settlement contracts including but not limited to accelerated death benefits policy offered by the issuer of the life insurance policy. You are advised to consult a financial advisor, certified public accountant and/or an attorney regarding these potential alternatives.

2. Some or all of the proceeds of the life settlement contract may be taxable. **Welcome Funds, Inc** is not a tax advisor and recommends that you seek assistance from a professional tax advisor regarding this transaction.

3. Proceeds from the life settlement contract could be subject to the claims of creditors.

4. Receipt of the life settlement contract proceeds may adversely affect your eligibility for public assistance or other government benefits or entitlements and advice should be obtained from the appropriate agencies.

5. You have the right to terminate (rescind) a life settlement contract within fifteen (15) days of the date (i) the contract is executed by all parties; and (ii) you have received the disclosures specified herein. Such termination or rescission shall be effective only if both notice of rescission is given to the provider and you repay all proceeds and any premiums, loans and loan interest paid by the provider during the rescission period. If the insured dies during the rescission period, then the contract shall be deemed rescinded, subject to you or your estate's repayment of all proceeds and any premiums, loans and loan interest to the provider.

6. Proceeds from the life settlement contract 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 and the beneficiary has been designated in accordance with the terms of the life settlement contract. **Welcome Funds, Inc** and your referring advisor, if any, has no access to or control over provider funds that are set aside in escrow or trust.

7. Entering into a life settlement contract and the subsequent change of ownership may cause other rights or benefits, including conversion rights and waiver of premium benefits, which may exist under the policy or a certificate of a group life insurance policy to be forfeited – assistance should be sought from a financial advisor.

8. Total compensation payable to both **Welcome Funds, Inc** and your referring advisor/broker, if any, shall collectively be calculated as a percentage of the contingent offer obtained for the sale of your existing life insurance policy. Your proceeds are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the provider reduced by the total compensation as described above. Actual total compensation shall be disclosed no later than the date the life settlement contract is signed by all parties.

9. You have the right to know the date by which funds will be available to you and the identity of the transmitter of such funds.

10. I/we confirm and acknowledge that **Welcome Funds, Inc** has provided me/us with a brochure/guide describing the process of life settlements that serves as a consumer advisory package.

[Additional Disclosures on Next Page]

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NOTICE OF DISCLOSURE (PAGE 2 OF 2)

11. All medical, financial or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members or a spouse or a significant other, may be disclosed as necessary to effect the life settlement contract between the policy owner and provider. 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. In addition, information regarding the policy owner's and insured's identity and insured's medical condition will i) be shared with the insurer that issued the life insurance policy; and ii) shall be available to each subsequent owner of the life insurance policy.

12. The insured may be contacted by the provider or broker or an authorized representative of the provider or broker 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 year, and 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 the affiliation, if any, between the provider and the issuer of the insurance policy to be settled.

14. **Welcome Funds, Inc** and your referring advisor/broker, if any, represents exclusively you and not the insurer or provider or any other person and owes you a fiduciary duty, including to act according to your instructions and in your best interest notwithstanding the manner in which **Welcome Funds, Inc** and your referring advisor/broker, if any, is compensated.

15. You have the right to know the name, address and telephone number of the provider.

16. You have the right to know the name, address and telephone number of the independent third party escrow agent. In addition, you may inspect or receive copies of the relevant escrow or trust agreements or documents.

17. Change of ownership could in the future limit the insured's ability to purchase future life insurance coverage on the insured's life because there is a limit to how much coverage insurers will issue on one life.

18. **Welcome Funds, Inc** recommends that you read the life settlement contract and seek assistance from a professional financial advisor and/or consult with your legal advisor prior to signing it.

I/We acknowledge that I/we have read and understand the disclosures above (1-18).

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 Representative of Welcome Funds Inc**	Printed Name	Date

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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,* c*onfirmation and status of change in ownership designations and any other general information about my coverage.*

WELCOME FUNDS INC makes it hereby known that the insured or 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 and will expire on the date of the Insured's death 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 **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

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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

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____ (the undersigned individual), 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, clinician, 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 further 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, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete 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, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (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, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), 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 an Authorized Recipient to a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
4. **Expiration of Authorization.** 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 at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted 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"); 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 or other privacy laws and 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 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 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)

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ______________________________________ (the undersigned individual), 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, clinician, 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 further 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, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete 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, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (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, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), 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 an Authorized Recipient to a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
4. **Expiration of Authorization.** 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 at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted 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"); 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 or other privacy laws and 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 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 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)

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NON-EXCLUSIVE BROKER AUTHORIZATION & SERVICES AGREEMENT

Do you have a referring advisor/broker working with WELCOME FUNDS INC and authorized to a) represent your interests regarding this Evaluation Request & potential transaction; & b) accept offers, if any, on your behalf?

☐ Yes ☐ No If Yes, then please provide the name(s) of such advisor(s)/broker(s) below:

Name of **Referring Advisor /Broker #1** ____________________ Name of **Referring Advisor/Broker #2** (if applicable) ____________________

WELCOME FUNDS INC works exclusively in the secondary market for life insurance by representing the best interests of consumers and maximizing the sales value of their policy(ies). As your designated broker, WELCOME FUNDS INC incurs the necessary, required and related costs to facilitate the sale of your policy while providing the following services including but not limited to:

- Evaluation Form assessment.
- Obtaining and forwarding independent third party life expectancy reports.
- Best execution negotiation to maximize fair market value of the sale of your policy.
- Medical underwriting & insurance verifications.
- Submission to multiple authorized and/or registered buyers of life insurance policies.
- Closing services including contract review & assistance with contingency requirements of buyers of life insurance policies.

In consideration of the services provided and related costs incurred as described above, I/We authorize WELCOME FUNDS INC to act as my/our non-exclusive broker and to evaluate, underwrite, solicit, generate and secure conditional offers regarding and/or related to the purchase of the following life insurance policy(ies):

1st Policy No. __________ issued by ____________________ (**Name of Insurance Carrier**). 2nd Policy No. __________ (if applicable) issued by ____________________ (**Name of Insurance Carrier**).

Furthermore, by signing this authorization and agreement, I/we am/are:

1. Granting to WELCOME FUNDS INC the authority to evaluate, underwrite, solicit, generate and secure conditional and appropriate offers as determined by WELCOME FUNDS INC pursuant to its typical business model, methods and practices, for the sale of my/our life insurance policy(ies) as stated above.
2. Recognizing the proprietary nature of such appropriate, conditional offers as evaluated, underwritten, solicited, generated and secured by WELCOME FUNDS INC for the period of time as described above and pursuant to this Broker Authorization & Services Agreement.
3. Agreeing to the total compensation, as described in this paragraph, payable to WELCOME FUNDS INC and your referring advisor/broker, if any. Such compensation shall collectively be calculated as a percentage of the contingent offer obtained for the sale of your existing life insurance policy. Your proceeds 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 total compensation shall be disclosed no later than the date the life settlement contract is signed by all parties.
4. Aware that WELCOME FUNDS INC issues no guarantee that my/our life insurance policy will be sold, is under no obligation to purchase my/our policy or to ultimately find a buyer of my/our policy(ies) and is not responsible for any breach committed by a buyer if one is identified.

Agreed to & Accepted by:

Signature	Printed Name	Date
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

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Important Information You Should Know
Before Entering Into a Life Settlement

General Information

What is the purpose of this shopper's guide?

The State of Texas requires the delivery of this guide to assist Texas residents who are the original owners of a life insurance policy that they are considering selling. Questions related to investing in life settlements should be directed to the Texas State Securities Board.

What is a life settlement?

A life settlement is the sale of a policy for an amount less than the policy's expected death benefit. Only the owner of a policy may sell the policy. The owner may be a different person than whose life is covered by the policy. A life settlement offers a policy owner the opportunity to get a portion of the death benefit while the insured is still alive.

How does a life settlement work?

The person that buys a life insurance policy from the owner is called a life settlement provider (provider). The owner may also choose to hire a life settlement broker (broker) to negotiate the life settlement contract with a provider. Providers and brokers will ask you and the insured to complete an application and medical release forms so they can get information from your life insurance company and the medical records of the insured.

If you qualify, the provider will make an offer to purchase your policy. If you accept the offer, the provider will ask you to sign a contract.

Are providers and brokers licensed by the state?

Life settlement providers and brokers must be licensed by the Texas Department of Insurance (TDI). You may check to see if they have a license here: www.tdi.texas.gov/life/viaintro.html.

What is my policy worth?

Texas law requires that the minimum value for a life settlement contract be greater than a cash surrender value or accelerated death benefit available at the time you apply for a life settlement contract. Providers will base the amount of the offer on facts such as how long the insured is expected to live, the amount you pay for premiums, the rating of your insurance company, and your policy's provisions (such as a waiver of premium). You may want to get quotes from several providers to ensure you get the best offer.

Will personal information remain confidential?

A provider or broker may not share any financial, medical, or personal information about the owner or insured with anyone, including your family members, unless there is

written approval to share the information. Any written approval must show who may get the information and why it will be released. The provider or broker may share the information with someone who buys the policy or provides funds for the purchase. The provider or broker may ask the individual to renew permission to share information every two years.

What should I know about a life settlement contract?

Once sold, your policy might be resold to entities or individuals not licensed by TDI. A broker represents the policy owner exclusively. A broker owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

The provider or broker must provide the owner with consumer disclosures, including the compensation the provider will receive, all offers and counteroffers, risks related to taxes and government benefits, and other additional information. Read these disclosures carefully.

TDI must approve all life settlement contract and disclosure forms.

Entering a life settlement will affect:

- whether your beneficiaries will receive any benefits from the policy
- any policy cash values, loans, or dividends
- some rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy

In addition, a life settlement may affect:

- your taxes
- your ability to receive supplemental social security income, public assistance, and public medical services including Medicaid
- your debt obligations, creditors, personal representatives, trustees in bankruptcy, and receivers in state or federal court may try to take away the money you receive for your life settlement
- the ability to obtain future life insurance
- life insurance coverage on spouses or other family members, if the policy (or any riders attached to it) covers their lives

Talk to an attorney, accountant, estate planner, financial planning advisor, tax advisor, social services agency, or your insurance company or agent to find out what effect selling your policy will have on you.

Can an owner keep a portion of the policy’s benefits?

Yes. Some providers offer policy owners the opportunity to retain a portion of the death benefits.

What if my policy includes extra coverages like accidental death, future increases in the death benefit, or coverage for other family members? Do these affect my settlement?

You may contact your insurance company or agent to see if your policy includes extra coverages.

If your policy includes a benefit for accidental death, your settlement might not include the additional death benefit. The additional death benefit will remain payable to your beneficiaries or your estate.

If your policy provides future increases in the death benefit, ask how much the provider is paying you for the purchase of this benefit.

If your policy is a joint policy or provides coverage on the lives of other family members or anyone other than yourself, there may be a possible loss of coverage for those people.

Are there other options available besides selling my policy?

Your insurance company might offer options, such as accelerated death benefits, loans, and surrender of the policy for its cash value. Before selling a life insurance policy, contact your insurance company or agent to see what options are available.

After you sell your policy

When and how will I get my money?

A provider must send you the money within three business days after it receives notice from the insurer or group administrator that ownership of the policy has been transferred.

What if I change my mind?

You may cancel a life settlement contract at any time up to the 15th day after the date of the contract. To cancel the life settlement contract, you must return any money the provider paid to you, along with any premiums, loans, and loan interest the provider paid. Remember to arrange with the provider to have the insurance company transfer the ownership of the policy back to you.

What if the insured dies shortly after selling the policy?

If the insured dies within 15 days after the execution of the contract, the provider must rescind the settlement contract if you or your estate repays all money to the provider, along with any premiums, loans, and loan interest the provider paid.

What happens after I get my money?

After the provider has paid you, it may begin to check on the health of the insured. If the life expectancy of the insured is one year or less, the providers may check health status once per month. If the insured is expected to live for more than one year, contact is limited to once every three months.

What if the insured doesn't want to be contacted about his or her health status?

The insured may appoint another adult to be contacted. That person must be someone who is in regular contact with the insured. The insured can change the contact person at any time by sending a written notice to the provider.

How will I know who will be calling about the insured's health status?

The provider must give you the name, address, and phone number of the person who will call the insured or the insured's contact person(s) about the insured's health status.

Will the provider call the insured's doctor to check on their health status?

Some providers will check with the insured's doctor for updates on his or her health. The medical release form allows the insured's doctor to give medical information to the provider or broker.

Does anyone make money or commissions from the sale of my policy?

Yes. The provider or broker must provide the owner the names of all the people who have or will receive some type of payment from the purchase or sale of your policy, along with the amount and terms of the payment. Your broker must disclose all offers that were made for your policy, the amounts received by all brokers on the sale, and a complete reconciliation of the offer by the provider to the amount you receive.

Complaints

You may submit a complaint to TDI by:

- writing to the Texas Department of Insurance, Consumer Protection, Mail Code 111-1A, P.O. Box 149091, Austin, Texas 78714-9091
- calling the Consumer Help Line at 1-800-252-3439 between 8 a.m. and 5 p.m., central time, Monday through Friday
- faxing your complaint to TDI at 1-512-475-1771
- filing your complaint online at www.tdi.texas.gov/consumer/complfrm.html, or
- emailing your complaint to consumer.protection@tdi.texas.gov