

# WELCOME FUNDS INC., A VIATICAL SETTLEMENT BROKERAGE

Toll Free: 1-877-227-4484  
Phone: 561-862-0244  
Fax: 561-862-0242

301 Yamato Road  
Suite 2110  
Boca Raton, FL 33431-4929

## CALIFORNIA VIATICAL SETTLEMENT APPLICATION CHECKLIST

Date: _____ / _____ / _____
Insured's Name: _____ Age _____ Years.

The information you provide on this application packet will allow Welcome Funds Inc., A Viatical Settlement Brokerage (WFI) to evaluate your request to sell your life insurance policy. Please answer the questions completely and to the best of your knowledge and ability. All of the information provided to WFI on these documents will be held in the strictest confidence. Please return the application and materials to WFI using the return envelope provided.

### PLEASE CHECK THE FOLLOWING

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- \_\_\_\_\_ Completed "Application" and Signed "Release of Information" forms.
- \_\_\_\_\_ Copies of Other Documents Required From Page 2 of the Application.
- \_\_\_\_\_ A Copy of your insurance policy(s).
- \_\_\_\_\_ Copies of Medical Records from all physicians you have seen within the last 3 to 4 years. This includes office notes, labs, pathology reports, etc. (Our staff will obtain these if necessary)

**PLEASE USE THIS FORM AS A GUIDE FOR SUBMITTING ALL NECESSARY FORMS. IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CONTACT US AT: 1-877-227-4484**

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## APPLICATION FOR VIATICAL SETTLEMENT State of California Viatical Settlement Application

### INSURED'S PERSONAL INFORMATION

INSURED NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

CURRENT HOME ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER (DAY) TELEPHONE NUMBER (EVENING)

Single  Married  Widowed  Divorced

PLEASE CHECK MARITAL STATUS ABOVE

INSURED'S DRIVERS LICENSE # & STATE MALE / FEMALE PLACE OF BIRTH

### INSURED'S MEDICAL INFORMATION

NAME OF PRIMARY ATTENDING PHYSICIAN DATE LAST SEEN TELEPHONE NUMBER

ADDRESS

CITY STATE ZIP CODE

NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #1

NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #2

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

ADDITIONAL MEDICAL HISTORY

ADDITIONAL MEDICAL HISTORY

If you have any additional physicians or medical information to inform us about, please attach a separate sheet with complete details.

## LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY	POLICY NUMBER	ISSUE DATE
<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Joint Survivorship	<input type="checkbox"/> Other

TYPE OF POLICY (PLEASE CHECK ONE)

IF POLICY IS A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP

<input type="checkbox"/> Term	<input type="checkbox"/> Whole Life	<input type="checkbox"/> UL	<input type="checkbox"/> Group	<input type="checkbox"/> Other
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CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

FACE AMOUNT	TOTAL POLICY LOAN AMOUNT	CASH SURRENDER VALUE
<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly		\$

POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX)      PREMIUM AMOUNT

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

ADDITIONAL BENEFICIARIES

WHAT IS THE SPECIFIC PURPOSE FOR THE SALE OF THE POLICY OR POLICIES?

## POLICY OWNER INFORMATION

NAME OF POLICY OWNER	SOCIAL SECURITY OR TAX ID NUMBER
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NAME OF PRESIDENT / TRUSTEE (IF CORPORATE / TRUST OWNED POLICY)	DATE OF INCORPORATION / TRUST
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HAS POLICY OWNER EVER DECLARED BANKRUPTCY?	IF SO, HAS IT BEEN DISCHARGED?	WHEN?
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ADDRESS	TELEPHONE NUMBER
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CITY	STATE	ZIP CODE
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## FINANCIAL PROFESSIONAL INFORMATION

NAME OF REFERRING FINANCIAL PROFESSIONAL	TELEPHONE NUMBER
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IF A FINANCIAL PROFESSIONAL DID NOT REFER YOU, HOW DID YOU FIND OUT ABOUT OUR COMPANY?

# **IMPORTANT ADDITIONAL INFORMATION REQUIRED**

**Please include the following documents with your application, if applicable. This will allow us to process your application much more efficiently.**

- 1. PHOTOCOPY OF TWO FORMS OF ID** (i.e. Driver’s License, SS Card, etc.), (Insured and Policy Owner)
- 2. PHOTOCOPY OF INSURANCE POLICY OR POLICIES**
- 3. PHOTOCOPY OF TRUST OR CORPORATE PAPERS**
- 4. PHOTOCOPY OF DIVORCE DECREE** (Insured and Policy Owner)
- 5. PHOTOCOPY OF BANKRUPTCY DISCHARGE** (Insured and Policy Owner)

**If we do not receive this information, the processing of the application will be delayed.**

## **PERSONAL ACKNOWLEDGEMENTS**

I/we do represent that the information contained in this application is correct and accurate and you may rely thereon and that I/we will immediately notify Welcome Funds Inc., A Viatical Settlement Brokerage (WFI) of any changes in the information. I/we further give consent to WFI and its agents to release this application and all information gathered while processing including, but not limited to medical records, notes, and lab reports, pertaining to my illness for the purpose of soliciting the sale of my life insurance policy. I/we acknowledge that I/we am/are submitting this application for you to evaluate the purchase of the life insurance policy freely and voluntarily and I/we acknowledge that I/we have a full and complete understanding of the terms of the potential settlement. Furthermore, I/we understand and acknowledge that WFI and the various providers WFI works with are under no obligation to purchase my policy.

**Please note:** “Any person who knowingly presents false information in an application for insurance or a viatical contract is guilty of a crime and may be subject to fines and confinement in prison.”

\_\_\_\_\_  
**Signature of Patient / Insured** Printed Name Date

\_\_\_\_\_  
**Signature of Witness** Printed Name Date

\_\_\_\_\_  
**Signature of Policy Owner (*if not Insured*)** Printed Name Date

\_\_\_\_\_  
**Signature of Witness** Printed Name Date

**NOTICE OF DISCLOSURE**

- 1. Receipt of payment under a Viatical Settlement may affect your eligibility for public assistance programs, such as SSO, MediCal, Food Stamps, medical assistance (Medicaid), aid to families with dependent children, supplementary social security income, AIDS drug assistance programs, and other governmental benefit programs; and it also may be taxable and subject to claims of your creditors. Before applying for a life insurance settlement, you should consult with the appropriate social services agency such as the Social Security Administration or the State Department of Social Services under Section 11022 of the Welfare and Institutions Code, concerning how receipt could affect your eligibility and that of your spouse or dependents.
- 2. There may be certain tax consequences associated with selling a life insurance policy. The Health Insurance Portability and Accountability Act of 1996 makes the proceeds from Viatical Settlements free from Federal taxes for people whose life expectancy is less than 24 months, or who are chronically ill (under special circumstances). While some states may, California does not tax the proceeds from Viatical Settlements. Due to the complexities associated with this type of transaction and its various forms of taxable interest, Welcome Funds Inc. recommends that you obtain advice from a qualified financial or tax advisor.
- 3. Your insurance policy may offer options for you to receive a portion of your death benefit now without selling your policy. These options include accelerated or living benefits, which in some circumstances can provide more value than a Viatical Settlement. Some policies may offer such options even if they do not appear on the policy. We recommend that you obtain information from your insurance company regarding these options prior to selling your policy(ies).
- 4. As a viator or seller of this insurance policy(ies), you hereby consent to a Viatical Settlement, and you acknowledge that if this transaction is considered a Viatical Settlement that You, or the Insured does have a catastrophic or life threatening illness, and that You, and the Insured have a full and complete understanding of the Viatical Settlement Transaction.
- 5. You have the absolute right to rescind the sale of any policy at any time up until fifteen (15) days after signing a Viatical Settlement Agreement by notifying the Viatical Settlement Provider. Any waiver or settlement language attempting to nullify this period shall be considered void pursuant to Section 10113.2(n) of the California Insurance Code.

Welcome Funds Inc., A Viatical Settlement Brokerage, pursuant to Section 10113.2(d) of the California Insurance Code, is making this disclosure to you.

I, the Applicant and/or Policy Owner, do hereby acknowledge that I have read and understand the contents of this disclosure and I am entering into this application for the sale of a life insurance policy, freely and voluntarily.

<b>Signature of Patient / Insured</b>	Printed Name	Date
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<b>Signature of Witness</b>	Printed Name	Date
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<b>Signature of Policy Owner (<i>if not Insured</i>)</b>	Printed Name	Date
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<b>Signature of Witness</b>	Printed Name	Date
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## Authorization for the Release of Information - HIPAA Compliant

I, \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ (*Patient / Insured*), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, identified below (as each, "Authorized Discloser", hereafter referred to as, "AD"), insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Welcome Funds Inc. and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers. (hereafter referred to as, "WFI"), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV/Aids, or drug or alcohol abuse, of or relating to the insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand and it is my intention that the requested information may include, and will not be limited to, the results of any HIV tests or other AIDS-related information, including all T-Cell and Viral Load information as well as any psychiatric evaluations and/or information. I specifically waive the provisions of California Health and Safety Code Section 199.21 et seq. relating to such information, and the provisions of California Civil Code Section 56 (the "Confidentiality of Medical Information Act").

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by WFI about my coverage.

I also understand that WFI will only use the information pursuant to this Authorization for the purpose of a Viatical Settlement. Furthermore, I understand that WFI will not release any information to any person or organization except as may be otherwise lawfully required or as I may further authorize; I also understand that this transaction requires WFI to re-disclose the information to these necessary parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws; however WFI only works with companies that maintain the same HIPAA privacy standards. I acknowledge and understand that I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD, any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for thirty (30) months or until the policy is declined 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. I understand that all information that WFI and the providers and medical/insurance underwriting groups that WFI works with, will be kept strictly confidential and will not be released to the Medical Information Bureau.

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List of Authorized Disclosers: (I.E. Doctors, Hospitals, etc)

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<b>Signature of Patient / Insured</b>	Printed Name	Date
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Signature of Witness	Printed Name	Date
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<b>Signature of Policy Owner (<i>if not Insured</i>)</b>	Printed Name	Date
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Signature of Witness	Printed Name	Date
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