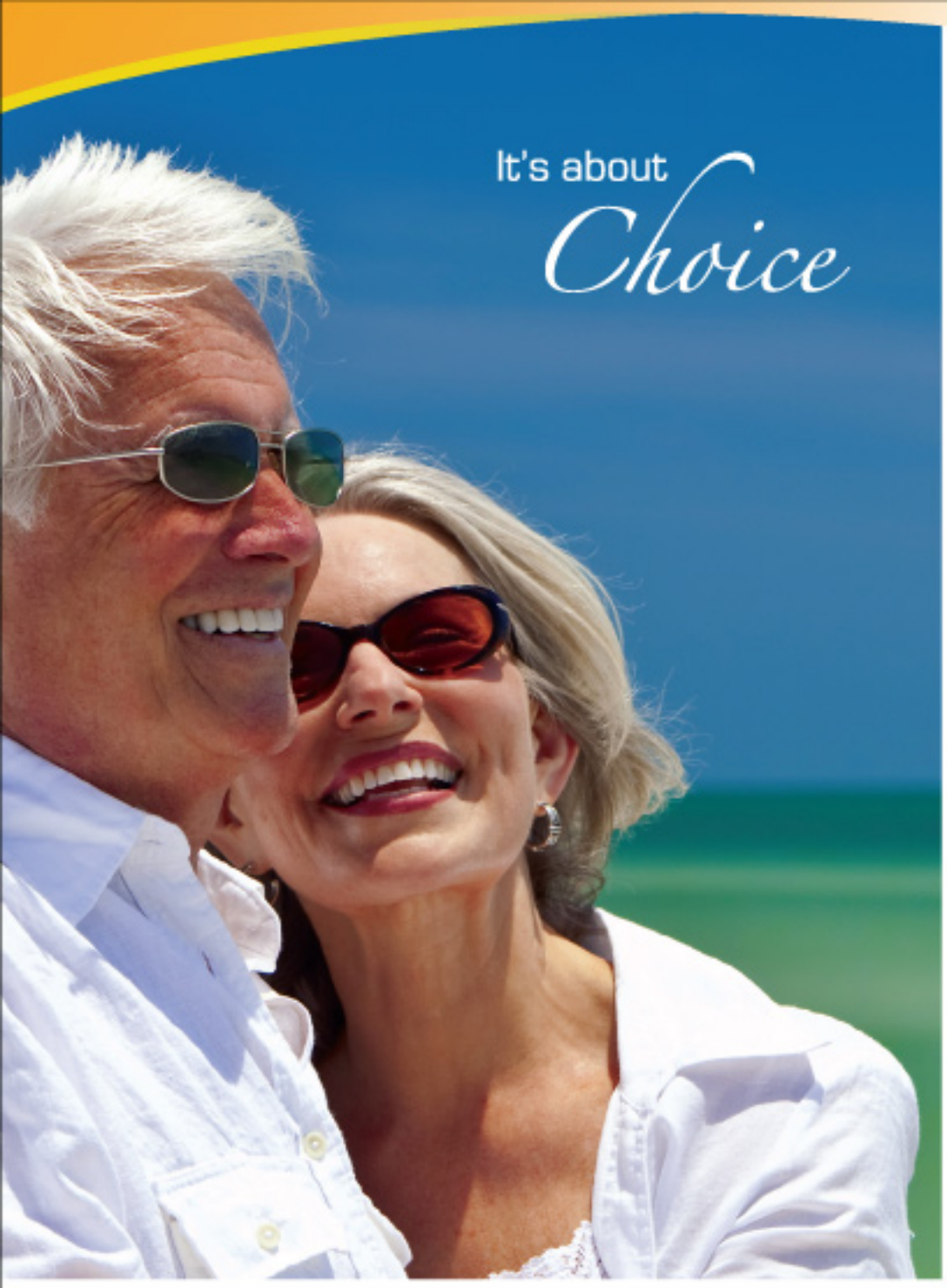

WELCOME FUNDS

Life Settlements. Simplified.®

IDAHO
STATE APPLICATION

1.877.227.4484

welcomefunds.com

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 Idaho

Life Settlement Endorsement Broker

State of Idaho

Department of Insurance

License No: 320905

NPN: 3421401

700 West State Street
P. O. Box 83720
Boise, ID
83720-0043

WELCOME FUNDS INC

NON-RESIDENT

LICENSE TYPE	LINES OF AUTHORITY	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE
Insurance Producer	Life	08/01/2023	07/31/2025
Life Settlement Broker	Life Settlement	08/01/2023	07/31/2025

Please verify the above information. If it is incorrect or if it changes, please notify the Licensing Section in writing immediately.

This license is subject to supervision or revocation by the State in accordance with Idaho law.

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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 by the Idaho Insurance Department titled, “Selling Your Life Insurance Policy: Understanding Life Settlements” to read and review 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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REQUIRED REFERRING ADVISOR/BROKER INFORMATION & ATTESTATION (IF APPLICABLE)

This page is to be completed & signed by Referring Advisors/Brokers ONLY.
If there is no Referring Advisor/Broker, then please skip this page.

As a necessary requirement to help facilitate & to receive compensation related to this potential transaction, please attach ALL applicable licenses described below (some states may not require/issue a broker license).

Life Insurance Policy # 1

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 2 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 3 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Life Insurance Policy # 4 (if applicable)

Policy Owner: _____
Policy Number: _____
State of Policy: _____
Insurance Carrier: _____

Referring Advisor/Broker Information

Name: _____

Relevant Valid State Producer License # & Expiration: _____

Relevant Valid State Broker License # & Expiration (if applicable): _____

Referring Advisor/Broker Signature

I hereby attest that the above Referring Advisor/Broker Information is true and accurate and that I am, during the potential or actual sale of the existing life insurance policy(ies) described above a) authorized to represent the above Policy Owner(s) and to accept offers on his/their behalf; b) the primary and often only direct contact with such Policy Owner(s) to determine suitability and the value and merit of selling the existing life insurance policy(ies) described above; c) representing the Policy Owner(s) in a fiduciary capacity and always in the best interest of the Policy Owner(s); and d) warranting that I have reviewed the disclosure statements contained in the "Notice of Disclosure" herein with such Policy Owner(s).

_____
Signature of Referring Advisor/Broker Date

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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. Complete Medical History Dating Back at least Two (2) Years Prior to the Issuance of the Policy 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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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.

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?**

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

FINANCIAL INFORMATION (REQUIRED FOR SUITABILITY REVIEW)

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 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.

☐ Please check here if Policy Owner(s) chooses not to complete the information below and declines the assistance the Welcome Funds Inc in determining suitability.

Policy Owner's Net Worth
(please check one)

- ☐ **$0 - $49,999.00**
- ☐ **$50,000 - $99,999.00**
- ☐ **$100,000.00 - $199,999.00**
- ☐ **$200,000.00 - $499,999.00**
- ☐ **$500,000.00 - $999,999.00**
- ☐ **$1,000,000.00 - $2,499,999.00**
- ☐ **$2,500,000 - $4,999.999.00**
- ☐ **$5,000,000 +**

Reason For Considering Sale
(check ALL that apply)

- ☐ **Planning to surrender or allow policy to lapse**
- ☐ **No longer want or need coverage**
- ☐ **Premiums have become too costly**
- ☐ **Alternative to a 1035 exchange**
- ☐ **Seeking replacement policy**
- ☐ **Estate planning needs have been met**
- ☐ **Need cash liquidity for health & living expenses**
- ☐ **Interested in determining market value of policy**
- ☐ **Other (please describe):**

_____

_____

Verified & 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

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 Policy Owner #1: (if not Insured): ☐ Yes ☐ No

Secondary Insured (if applicable) ☐ 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.

[Continued on Next Page]

PERSONAL ACKNOWLEDGEMENTS (CONTINUED)

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 <u>not</u> Insured)	Printed Name	Date
_____	_____	_____
Signature of **Policy Owner #2** (if <u>not</u> Insured)	Printed Name	Date

DISCLOSURE TO OWNER

(To be provided no later than at time of application for any life settlement agreement)

(With acknowledgement of life settlement provider or broker)

IMPORTANT – READ THIS DISCLOSURE FORM AND THE ENCLOSED LIFE SETTLEMENT INFORMATION BROCHURE BEFORE SIGNING ANY LIFE SETTLEMENT AGREEMENT.

You should carefully read all of the following points and seek financial, insurance, tax and other advice where appropriate.

1. Possible alternatives to life settlement contracts include any accelerated death benefits or policy loans offered under your life insurance policy.

2. A life settlement broker exclusively represents you, the owner, and not the insurer or the life settlement provider, and 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.

3. Some or all of the proceeds of the life settlement may be taxable under federal and state law, and assistance should be sought from a professional tax advisor.

4. Proceeds of the life settlement could be subject to the claims of your creditors.

5. Receipt of the proceeds of a life settlement may adversely affect your eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies.

6. You have the right to rescind (cancel) a life settlement contract within twenty (20) days of the date it is signed by all parties. If you want to rescind the contract, you must provide notice to the life settlement provider and repay all proceeds and any premiums, loans and loan interest paid on account of the life settlement contract within the twenty (20) day rescission period. If the insured dies during the twenty (20) day rescission period, the life settlement contract will be deemed to have been rescinded, subject to repayment by the owner or the owner's estate of all life settlement proceeds and any premiums, loans and loan interest.

7. Funds will be sent to you within three (3) business days after the life settlement provider has received the insurer or group administrator's written acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated.

8. Entering into a life settlement contract may cause you to forfeit other rights or benefits including conversion rights and waiver of premium benefits that may exist under the policy or certificate. Assistance should be sought from a financial adviser.

Policy Owner's Initials: _____

9. You will be provided a brochure approved for use by the Department of Insurance that describes the process of life settlements. You should review this brochure carefully.

10. All medical, financial or personal information solicited or obtained by a life settlement provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the life settlement between the owner and the life settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided 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.

11. Following execution of a life settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided in sections 41-1950 through 41-1965, Idaho Code. This contact shall be limited to once every three (3) months if the insured has a life expectancy of more than one (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less. All such contacts shall be made only by a life settlement provider licensed in the state of Idaho.

12. If you have any questions, you may call the Idaho Department of Insurance at 800-721-3272 or 208-334-4250.

LIFE INSURANCE POLICY OWNER'S ACKNOWLEDGMENT: I have read and fully understand this disclosure form. I have received copies of this disclosure form and the life settlement information brochure to keep for my records.

LIFE INSURANCE POLICY OWNER

By: _____

_____
Printed Name

Date: _____

LIFE SETTLEMENT PROVIDER OR BROKER

By: _____

_____
Printed Name/Title

Date: _____

JOINT LIFE INSURANCE POLICY OWNER

By: _____

_____
Printed Name

Date: _____

WELCOME FUNDS INC.
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BOCA RATON, FL 33431

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

WELCOME FUNDS INC makes it hereby known that 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 two (2) years from the date of this Authorization, 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. 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

_____
Owner's Initials

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

(PRIMARY INSURED)

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, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I 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 any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each, and to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, underwrite and solicit bids for the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, brokers/brokerages, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and his or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (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 and medical data, information and records, 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 the Authorized Recipient to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured. In addition, I acknowledge that some state and federal laws prohibit the further disclosure of drug, alcohol or HIV related information without specific written consent. This authorization shall serve as such consent in order for each Authorized Recipient to perform the functions described herein.

4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.

5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action 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 HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

[Continued on Next Page]

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 Privacy Regulations"); 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 Privacy 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 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)

WELCOME FUNDS INC.
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BOCA RATON, FL 33431

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PHONE: 561.862.0244
FAX: 561.862.0242
WWW.WELCOMEFUNDS.COM

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

(SECONDARY INSURED)

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, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I 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 any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each, and to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, underwrite and solicit bids for the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, brokers/brokerages, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and his or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (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 and medical data, information and records, 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 the Authorized Recipient to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured. In addition, I acknowledge that some state and federal laws prohibit the further disclosure of drug, alcohol or HIV related information without specific written consent. This authorization shall serve as such consent in order for each Authorized Recipient to perform the functions described herein.

4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.

5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action 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 HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

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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 Privacy Regulations"); 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 Privacy 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 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** (Secondary Insured)	Printed Name	Date
_____	_____	_____
Signature of **Legal Representative** of Secondary 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)

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
SUITE 202
BOCA RATON, FL 33431

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
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WWW.WELCOMEFUNDS.COM

BROKER AUTHORIZATION & SERVICES AGREEMENT (PAGE 1 OF 2)

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.
- Medical underwriting & 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 & 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 broker and to evaluate, underwrite, solicit, generate and secure conditional offers beginning on the date of execution of this Agreement and continuing for 180 days after the final offer is obtained/acquired 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. _____ issued by _____.
(if applicable) **Name of Insurance Carrier**

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

1. Granting to WELCOME FUNDS INC the authority, beginning on the date of execution of this Agreement and continuing for 180 days after the final offer is obtained/acquired by WELCOME FUNDS INC, 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.

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3. Agreeing to the total compensation, as generally 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. Actual total compensation stated as a specific dollar amount and such compensation stated as a percentage of the life settlement offer shall be disclosed as part of a separate disclosure form 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 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

Questions To Ask

- Do I still need life insurance protection?
- Will I qualify for a new life insurance policy in the future?
- If I sell my policy, how will they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need their permission to sell it?
- If I sell my policy, who will be the legal owner?
- Can the policy be resold?
- Who will have specific information about me, my family or my health status?
- Is the broker or company I plan to sell to allowed to do business in my state?

Always Check With the Idaho Department of Insurance

Contact your state insurance or securities department to learn about the issues and risks of life settlements if:

- You are considering selling your life insurance policy;
- You are asked to sell your life insurance policy *and* your health has not changed since you bought the policy;
- You are asked to buy a new life insurance policy for the purpose of selling it for cash. It is possible you are being targeted to participate in an illegal transaction.

State of Idaho Department of Insurance

700 West State Street
P.O. Box 83720
Boise, Idaho 83720

208-334-4250
800-721-3272
http://www.doi.idaho.gov

Revised May 2009

Selling Your Life Insurance Policy: Understanding Life Settlements

208-334-4250
800-721-3272
http://www.doi.idaho.gov

Understanding Life Settlements

A life settlement is the sale of a life insurance policy to a third party. The owner of a life insurance policy gets cash for the policy. The buyer becomes the new owner and/or beneficiary of the life insurance policy, pays all future premiums and collects the entire death benefit of the policy when the insured dies.

People decide to sell their life insurance policies for many reasons. Some common ones are changed needs of dependents, wanting to reduce premiums and cash for meeting expenses.

A life settlement may or may not be the right choice for you. Your state insurance department, along with the National Association of Insurance Commissioners, is concerned that many consumers may not fully understand life settlements. Please read on before making any decisions.

Consider Your Options

If you are selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

- Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.

Find out if your life insurance policy has an *accelerated death benefit.* An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Other Considerations

- Contact a professional tax advisor. Find out the tax implications. Proceeds are not tax-free. Know that creditors could claim the proceeds. Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you receive a cash settlement.
- The buyer of your policy can periodically ask you about your health status. ***The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read the notice carefully.***

Consumer Tips

- Understand how the process works and when different phases will happen.
- Decide whether to sell your policy directly to a life settlement provider or to go through a life settlement broker who will do the comparison shopping for you.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.

Make sure the life settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.

You have 20 calendar days after execution of the life settlement contract to change your mind and undo the sale. You must return the money you were paid and any premiums the buyer paid.

Defining The Terms

A **life settlement** is the sale of a life insurance policy to another person or company in return for cash now.

A **life settlement provider** is the person or company that becomes the new policy owner in return for a payment made to the seller. The buyer becomes the policy owner, must pay any premiums that are due and eventually collects the entire death benefit from the insurance company.

A **life settlement broker** is the person or company who represents the seller of the policy and can "comparison shop" for life settlement offers. The broker is paid a commission by the buyer if the sale is completed.