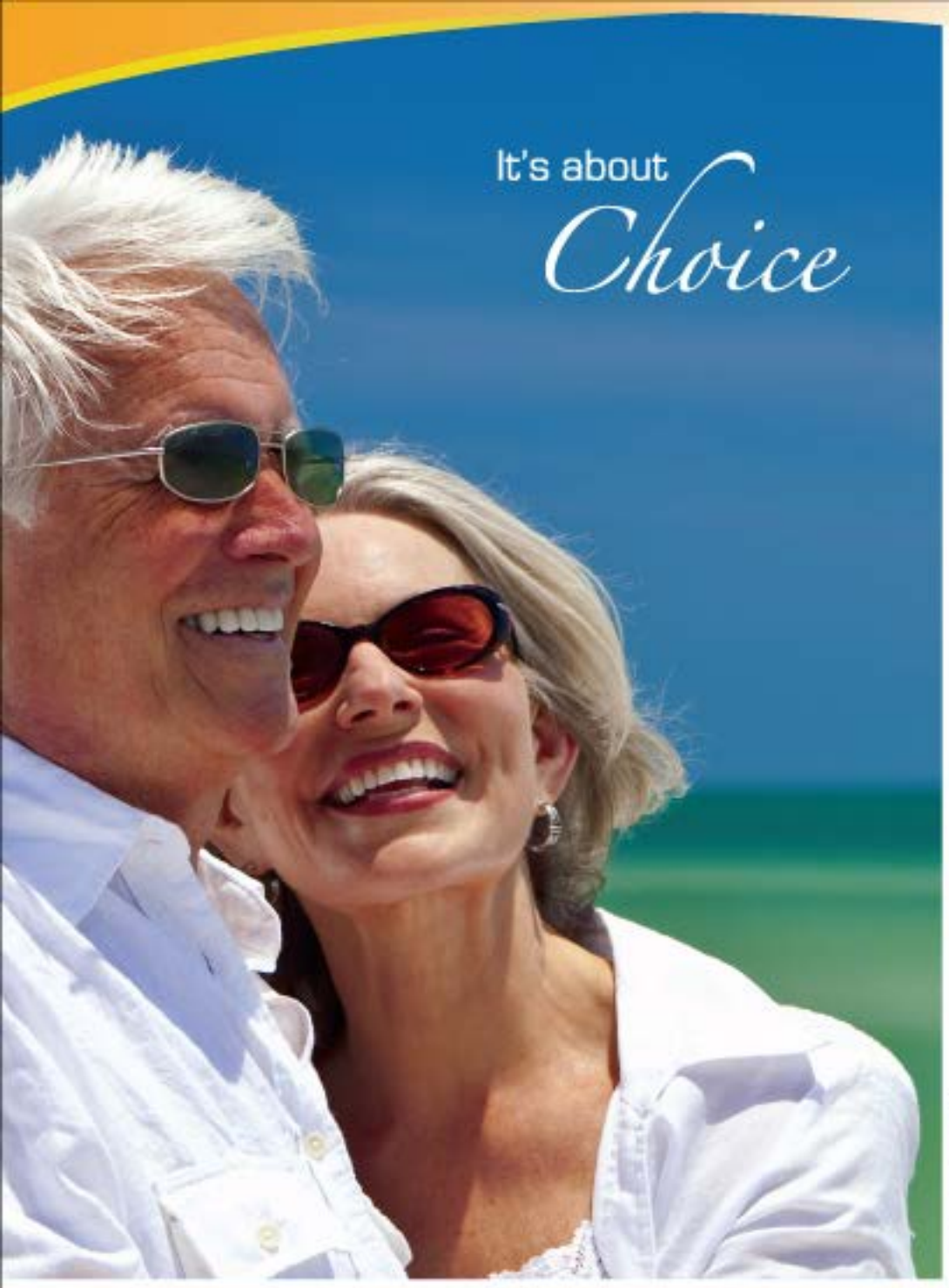

KANSAS

WELCOME FUNDS

Life Settlements. Simplified.®

KANSAS STATE APPLICATION

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 Kansas

Agency License

Kansas does not license entities for Viatical Settlements, therefore Welcome Funds is a licensed Insurance Producer in Kansas and transactions are facilitated through the Officer's Viatical Settlement Broker License.

Kansas Insurance License

NPN: 3421401

WELCOME FUNDS INC

By the authority vested in me by law as the Commissioner of Insurance in the state of Kansas, I hereby certify that the licensee named hereon is authorized to engage in the business of insurance in Kansas with the license types and lines of authority shown below.

NON-RESIDENT

LICENSE TYPE	LINES OF AUTHORITY	INITIAL LICENSE DATE	LICENSE EXPIRATION DATE
Insurance Producer	Lines Held by Employees	02/14/2008	02/28/2026

For questions regarding a license, contact: Kansas Insurance Department at kid.licensing@ks.gov or visit our website at insurance.kansas.gov.

Vicki Schmidt
Commissioner of Insurance

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A LETTER FROM THE FOUNDER

Dear Policy Owner/Insured:

As Founder & CEO of Welcome Funds, I would personally like to thank you for considering our team to serve as your personal representative in the secondary market for life insurance. We understand that you have choices in this process and we appreciate the opportunity to represent you. We also know that selling your life insurance policy is an important financial decision for you and your family, and our goal is to ensure that you are able to make this choice with confidence.

Welcome Funds is the one of the oldest and largest life settlement brokers in the United States and has assisted thousands of Americans since our founding in 2000. As your broker, we work diligently to represent your best interests during the entire transaction, from initial evaluation through the closing process. Our procedures consist of the following:

- Initial evaluation and review to determine eligibility;
- Evaluation Request assessment and processing;
- Medical records requests and life insurance policy verifications;
- Obtaining independent third party life expectancy report(s);
- Submission to authorized and/or state licensed secondary market buyers of life insurance policies;
- Best execution negotiations via an auction process in an effort to maximize the sales price of your policy;
- Closing services including contract review and assistance with closing contingency requirements.

In addition to the traditional procedure and lump sum cash settlements offered by the secondary market, we are also able to provide alternative options that you may want to consider, depending on your personal needs:

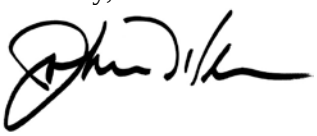
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the buyer paying all future premiums. This can include a combination of a cash payout & retaining a portion of the death benefit. This option may not be available in all states or for all policies; or
3. **Life Insurance Loans** – if you are interested in a loan using your life insurance policy as collateral, we can also work with multiple lending firms to secure financing. A loan option may not be available in all states or for all policies.

Please be sure to inform your advisor or your case manager if you would like to consider any of the above options. We would also like to recommend that you discuss the tax consequences of selling your life insurance policy with a tax advisor, as it is likely a taxable event, unless the insured qualifies for a viatical settlement or long-term care exemption in compliance with IRS codes. Additionally, we have attached a brief brochure for your review issued by the Kansas Insurance Department titled, "Selling Your Life Policy" to provide an unbiased, independent description of selling policies in the secondary market.

As a reminder, you are under no obligation to sell your life insurance policy, in fact, if you need your coverage and can afford to maintain it, we highly recommend that you do so!

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
Founder & CEO

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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

This request is not an agreement to purchase your policy and you are under no obligation to sell your policy by completing this form. The information that you provide in this request shall be used to evaluate and prepare your file, as required, to attempt to negotiate and secure a conditional offer or offers for the potential sale of your existing life insurance policy.

PRIMARY INSURED'S INFORMATION

PRIMARY INSURED NAME (FULL LEGAL NAME) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** | **TELEPHONE NUMBER**

CURRENT HOME ADDRESS | **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**

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

☐ Single ☐ Married ☐ Divorced ☐ Widowed

PLEASE CHECK APPICABLE MARITAL STATUS | **IF MARRIED/DIVORCE/WIDOWED, PLEASE PROVIDE FULL NAME OF (EX)SPOUSE**

SECONDARY INSURED'S INFORMATION (If Applicable – 2ND To Die / Survivorship Policies Only)

SECONDARY INSURED NAME (FULL LEGAL NAME) | **DATE OF BIRTH** | **SOCIAL SECURITY NUMBER** | **TELEPHONE NUMBER**

CURRENT HOME ADDRESS | **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**

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 medical information, then please attach a separate sheet with complete details.

LIFE INSURANCE POLICY INFORMATION

LIFE INSURANCE COMPANY | **FACE AMOUNT** | **POLICY NUMBER** | **ISSUE DATE**

☐ YES ☐ NO

POLICY LOAN AMOUNT (IF ANY) | **ACCUMULATED/CASH VALUE** (IF ANY) | **CASH SURRENDER VALUE** (IF ANY) | **CASH VALUE USED TO PAY PREMIUMS?**

☐ 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 OR YOUR HR DEPT. CONTACT

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

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

If Individually Owned *(if Insured is 100% Owner, skip to Bankruptcy Status):*

LEGAL NAME OF POLICY OWNER # 1 | **RELATIONSHIP TO INSURED** | **SOCIAL SECURITY NUMBER**

POLICY OWNER # 1 ADDRESS | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

LEGAL NAME OF POLICY OWNER # 2 (IF APPLICABLE) | **RELATIONSHIP TO INSURED** | **SOCIAL SECURITY NUMBER**

POLICY OWNER # 2 ADDRESS | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

IF THERE ARE MORE INDIVIDUAL 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 A POLICY OWNER EVER DECLARED BANKRUPTCY? | **IF SO, HAS IT BEEN DISCHARGED?** (PLEASE PROVIDE ALL BANKRUPTCY DOCS) | **WHEN WAS IT DISCHARGED?**

If Corporate or Trust Owned:

LEGAL NAME OF COMPANY OR TRUST | **RELATIONSHIP TO INSURED** | **TAX ID NUMBER**

COMPANY OR TRUST ADDRESS (OFFICIAL DOMICILE) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 1 | **LEGAL NAME OF AUTHORIZED COMPANY OFFICER OR TRUSTEE # 2**

TRUSTEE # 1 ADDRESS (IF DIFFERENT THAN TRUST) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

TRUSTEE # 2 ADDRESS (IF DIFFERENT THAN TRUST) | **CITY** | **STATE** | **ZIP CODE** | **TELEPHONE NUMBER**

For multiple policies, please reprint this page, then complete the above information and sign an insurance authorization form for each policy.

ADDITIONAL INFORMATION

PLEASE PROVIDE REASONS FOR INTEREST IN SELLING POLICY(IES), CHECK ALL THAT APPLY:

- ☐ Planning to lapse, cancel, or surrender the policy
- ☐ Health & living expenses are a financial burden
- ☐ Premium costs have become unaffordable
- ☐ Original purpose of policy no longer exists
- ☐ Other or provide further details: _____
- ☐ Proceeds from sale will help pay for medical treatments
- ☐ Considering a 1035 Exchange or replacement policy
- ☐ Cash liquidity preferred due to current financial situation
- ☐ Higher estate tax exemptions has eliminated need for policy

PLEASE VERIFY LEGAL CAPACITY OF POLICY OWNER(S) & INSURED(S):

If you choose to accept a contingent offer as a result of this preliminary application process, each individual Policy Owner(s) and Insured(s) may be required to have a Letter of Competency completed by an attending physician in order to verify their legal capacity to enter into an agreement to sell the life insurance policy. If the legal capacity of any party is questionable, we recommend obtaining an official Power of Attorney or Guardian ad Litem for that signatory as soon as possible.

Is there an existing Power of Attorney (POA) granting a legal representative the authority to act on behalf of a signatory or is there a Guardian ad Litem or similar legal representative acting on their 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) provide a full copy of the applicable legal documents (Durable POA or Medical POA) to verify the authority to sign on behalf of the signatory;
2) have the legal representative sign all signature lines for that party; 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)

PLEASE VERIFY SOURCE OF PREMIUM PAYMENTS AND/OR ASSIGNMENT OF POLICY:

1) Did the policy owner use a third-party to finance the premium payments? ☐ Yes ☐ No

   If **Yes**, then please:

   a) attach all loan documents, including contracts, trusts and/or corporate documents; and

   b) provide the name of the lender/financing company: _____
   Name of **Lender/Financing Company**

2) Is the life insurance policy being used as collateral for a loan or is there a current lien or assignment recorded with the life insurance carrier?

   ☐ Yes ☐ No

   If **Yes**, please provide all loan documents & name of lienholder/assignee: _____
   Name of **Lienholder/Assignee**

PLEASE VERIFY YOUR MARKET REPRESENTATION:

Are you working with any other third-party, other than Welcome Funds, related to the potential sale of your life insurance policy?

☐ Yes ☐ No

If **Yes**, please check all that apply:

☐ Financial Advisor ☐ Life Agent ☐ Attorney/CPA ☐ Settlement Broker ☐ Direct Buyer ☐ Direct Lender

PERSONAL ACKOWLEDGEMENTS

A. 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 as my/our broker for the potential sale of my/our life insurance policy. I/we also acknowledge that it is my/our responsibility to notify WELCOME FUNDS INC of any changes to this information, including any changes in health of the insured after this form has been submitted.

B. I/We understand that the market value of my/our life insurance policy is based in part on the health status and life expectancy of the insured. Current medical records for the insured are vital to obtain life expectancy assessments. These assessments are conducted by independent third-party life expectancy providers as required by the marketplace. WELCOME FUNDS INC is not responsible for the conclusions of these life expectancy providers and does not have the expertise to dispute those conclusions.

C. I/We acknowledge that WELCOME FUNDS INC is my/our broker who represents my/our best interests during the entire transaction process. I/We also understand and acknowledge that WELCOME FUNDS INC issues no guarantee that an offer will be secured for my/our policy.

D. I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial, insurance, medical and personal 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 review the information.

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

F. I/We acknowledge that I/we have been provided the following address/department to direct any consumer complaints that I/we may have: WELCOME FUNDS INC c/o Customer Complaints, to 4755 Technology Way – Suite 202, Boca Raton, FL 33431.

G. I/We understand and acknowledge that WELCOME FUNDS INC does not provide any advice as to whether or not to proceed with the sale of my/our life insurance policy and I/we are free to accept or decline any offer.

H. I/We understand and acknowledge that the policy owner is fully responsible for the timely payment of any and all premiums due for the policy that is the subject of this potential transaction, on the applicable due dates, up until change of ownership of the policy occurs, if a transaction is effectuated. I/We, not WELCOME FUNDS INC, assume sole responsibility if the policy lapses for failure to make timely payment of any and all premiums.

I. I/We would like to consider the following options in addition to a lump sum cash settlement offer (*subject to availability based on state residency, policy types and qualification requirements*):

☐ Retained Death Benefit (RDB) ☐ Cash Settlement with RDB ☐ Life Insurance Loan/Credit Line

☐ Expedited Bid Program (*may require additional disclosures*)

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

I/We acknowledge that I/we have read and understand the information provided above.

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 applicable & if not Insured)	Printed Name	Date

WELCOME FUNDS INC.
4755 TECHNOLOGY WAY
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KANSAS -- NOTICE OF DISCLOSURE

1. WELCOME FUNDS INC and your referring advisor/broker, if any, represents only you exclusively, not the insurer or the viatical/life settlement provider, and owes a fiduciary duty to you including the duty 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.
2. Some or all of the proceeds of your viatical/life settlement may be taxable under federal income tax and/or state franchise and income tax laws. WELCOME FUNDS INC is not a tax advisor and recommends that you consult your own professional tax advisor regarding this transaction.
3. The sale of your insurance policy may affect your right to receive Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
4. Viatical/life settlement proceeds could be subject to the claims of creditors.
5. There may be possible alternatives to selling your life insurance. This may include the option of an accelerated death benefit or policy loans offered by your life insurance company. You are advised to consult a financial advisor, certified public accountant and/or an attorney regarding these potential alternatives.
6. Once you have received your proceeds from the sale of your life insurance policy, you will have fifteen (15) calendar days from receipt of the viatical/life settlement proceeds in which to rescind the transaction. If the insured dies during the rescission period, then the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds and any premiums, loans and loan interest to the viatical/life settlement provider or purchaser.
7. Funds will be sent to you within three (3) business days after 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. WELCOME FUNDS INC and your referring advisor/broker, if any, has no access to or control over viatical/life settlement provider funds that are set aside in escrow or trust.
8. Entering into a viatical/life settlement contract may 1) 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; and 2) reduce the insured's ability to obtain additional life insurance coverage in the future.
9. Total compensation payable to WELCOME FUNDS INC and your referring advisor/broker, if any, shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds of your settlement are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the viatical/life settlement provider reduced by the total compensation as described above.
10. All medical, financial or personal information solicited or obtained by a viatical/life settlement provider or WELCOME FUNDS INC. about the insured, including the insured's identity or the identity of family members, a spouse or significant other may be disclosed as necessary to effect the viatical/life settlement between you and the viatical/life settlement provider. If you are asked to provide this information, you will be asked to consent to this 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 1) be shared with the insurer that issued the life insurance policy; and 2) shall be available to each subsequent owner of the life insurance policy.
11. The insured may be contacted by the viatical/life settlement provider or WELCOME FUNDS INC or either of its authorized representatives for the purpose of determining the insured's health status. This contact will be limited to no more frequently than once every three (3) months 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.
12. Any person who knowingly presents false information in an application for a viatical/life settlement contract is guilty of a crime and may be subject to penalty, including but not limited to fines and confinement in prison.
13. WELCOME FUNDS INC recommends that you read the viatical/life settlement contract and seek assistance from a professional financial advisor and/or consult with your legal advisor prior to signing it.
14. I/we confirm and acknowledge that WELCOME FUNDS INC has provided me/us with a brochure developed and approved by the Kansas Insurance Department describing the process of viatical/life settlements.

I/We acknowledge that I/we have read and understand the disclosures above (1-14).

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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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 the death of the Insured 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 **Policy Owner #1** _____ Printed Name _____ Date _____

Signature of **Policy Owner #2** (if any) _____ Printed Name _____ Date _____

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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** (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.
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** (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)

Consumer Alert

- If you are in good health and someone asks you to sell your life insurance policy, proceed with caution. You may be a target for fraud. Contact the Kansas Insurance Department for more information.
- If you have been contacted by someone who wants you to buy a policy and then sell it immediately, you should contact the Kansas Insurance Department. You may be a target for fraud.
- If you are asked to invest in a viatical settlement, we recommend you contact either the Kansas Insurance Department or the Kansas Securities Commission (785-296-3307) to learn more about the issues and risks that might be involved in such an investment.

Consumer Assistance
1-800-432-2484

This publication was issued as a public service by the
Kansas Insurance Department
Sandy Praeger, Commissioner

420 S.W. 9th St.
Topeka, KS 66612-1678

785-296-3071

E-mail: commissioner@ksinsurance.org
Homepage: www.ksinsurance.org

Selling Your Life Policy

What to Know About Viatical Settlements Before you sell Your Policy

Kansas insurance Department
Sandy Praeger, Commissioner

1-800-432-2484

Selling Your Life Insurance

Today it is possible for you to sell your life insurance policy to someone else and receive an immediate cash benefit to use for whatever reason you choose. This financial arrangement, known as a viatical settlement, is best suited for people who are living with immediate life-threatening illness and facing difficult financial choices.

It may not always be in your best interest to sell your policy. Before you take action, you want to be sure you understand

- *What future benefits you may lose*
- *What other options may be available*

This brochure is designed to provide some of that information. However, it only provides a starting point. If you have additional questions, please call us.

The Kansas Insurance Department
Consumer Assistance Division
1-800-432-2484

Make an informed decision

Have your needs changed?

- Before you sell your policy for cash you should carefully consider the loss of valuable insurance protection which you may not be able to get again. Remember that the costs for coverage increase significantly as you age and that you also must be in good health to qualify for coverage.

Check all of your options

- Find out if you have any cash value in your policy. You may be able to (1) borrow from the cash value, (2) cancel the policy for its current cash value, (3) use the cash value as collateral to secure a loan from a financial institution.
- Find out if you have an "accelerated benefit" rider on your policy. If available, it could pay you a substantial portion of your policy's death benefit without requiring you to sell your policy. It may be your best option.

Other considerations

- Check out the tax implications. Not all proceeds from a viatical settlement are tax free.
- Find out if the proceeds would be subject to the claims of any creditors.
- Find out if you will lose any public assistance benefits such as food stamps, unemployement, or Medicaid if you accept a cash settlement for your life policy.

Consumer protections in Kansas

- Any agent or company arranging viatical settlements must be licensed with the Kansas Insurance Department.
- The company buying your policy must keep your identity and medical history confidential unless you give them written consent.
- To protect your proceeds, the company buying your policy must put your money into an escrow account with an independent party during the transfer process.
- You have the right to change your mind about the settlement AFTER you receive the money, provided you return all the money. You have 15 days to review your settlement arrangement.
- The new owner of your policy is limited to the number of times they may contact you about your current health status.
- This is a summary of Kansas law. For more detailed information refer to Kansas Statute 1999 Supp.40-2, 140 eta.seq. or consult with your personal advisor.

A viatical settlement is a complex financial arrangement which may require professional guidance. We suggest you find your own personal advisor such as an accountant or tax attorney who will represent your interests.