It's about *Choice*

MONTANA

WELCOME FUNDS

Life Settlements. Simplified.®

MONTANA STATE APPLICATION

WELCOME FUNDS

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

TOLL-FREE: 877.227.4484
PHONE: 561.862.0244
FAX: 561.862.0242
WWW.WELCOMEFUNDS.COM

State of Montana

Insurance Producer License

State of Montana

License No: 3001910043

Insurance License

NPN: 3421401

Commissioner of Securities and Insurance Office of Montana State Auditor

WELCOME FUNDS INC.

Is licensed/authorized to engage in the business of insurance in the State of Montana in the capacity stated below:

LICENSE TYPE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY
Insurance Producer	04/25/2022		Life, Viatical

Authorized Individuals:

DANIEL OHMAN

An insurance producer may not claim to be a representative of a particular insurer unless the producer is an appointed Insurance producer of that insurer pursuant to 33-17-236, M.C.A. Failure to comply shall result in administrative action. This license is continuous provided that the individual(s) named has (have) complied with all Montana insurance license requirements, including any continuing education requirements. This license must be on display in the place of business of the licensee and shall at all times be the property of the State of Montana. it must be returned to the Commissioner upon termination, suspension or revocation.

Troy Downing
State Auditor
Commission of Securities and 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:

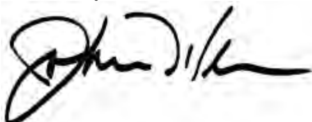
1. **Expedited Bid Process** – for situations that require a fast turnaround time due to the possibility of a lapse or a personal financial crisis;
2. **Retained Death Benefit Offers** – an offer to purchase the policy that includes a beneficiary of your choice maintaining some death benefit, with the 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 Consumer Guide to Understanding Life Settlements issued by the Kentucky Department of Insurance 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

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

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

PRIMARY INSURED'S PERSONAL INFORMATION

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

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

CITY | **STATE** | **ZIP CODE**

PRIMARY ATTENDING PHYSICIAN | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

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

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

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

CITY | **STATE** | **ZIP CODE**

PRIMARY ATTENDING PHYSICIAN | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

OTHER PHYSICIANS SEEN IN LAST 5 YEARS | **SPECIALTY** | **CITY/STATE** | **DATE LAST SEEN** | **TELEPHONE NUMBER**

HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

☐ Family Member ☐ Spouse ☐ Business Partner ☐ Other:________________________

PLEASE CHECK APPICABLE RELATIONSHIP TO PRIMARY INSURED (IF APPLICABLE)

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

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LIFE INSURANCE POLICY INFORMATION

LIFE INSURANCE COMPANY | POLICY NUMBER | ISSUE DATE

FACE AMOUNT | TOTAL POLICY LOAN AMOUNT | CASH SURRENDER VALUE

☐ Individual ☐ Joint Survivorship ☐ Group ☐ Other_______________

TYPE OF POLICY (PLEASE CHECK ONE)

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

☐ Term ☐ WL ☐ UL ☐ Other:_______________

CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly $_______________

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

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

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

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

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

CITY | STATE | ZIP CODE

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

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

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

☐ Family Member ☐ Spouse ☐ Business Partner ☐ Policy Owner is Insured ☐Other: _______________

IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK APPICABLE RELATIONSHIP TO INSURED

☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced – Date: __________

IF POLICY OWNER IS AN INDIVIDUAL, THEN PLEASE CHECK MARITAL STATUS

☐ YES ☐ NO ☐ YES ☐ NO Date:_______________

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

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

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ADDITIONAL INFORMATION

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

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

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

If the information below is not completed, then the policy owner(s) and insured(s) acknowledge that Welcome Funds Inc may not be able to provide recommendations it deems suitable, based on personal and specific financial needs, conditions and situations.

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

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

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

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

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

III. LIFE INSURANCE

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

Verified and Confirmed By:

Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if <u>not</u> Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if <u>not</u> Insured)	Printed Name	Date

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PERSONAL ACKNOWLEDGEMENTS

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

☐ Yes ☐ No

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

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

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

II. Have you signed a Power of Attorney (POA) granting a legal representative to act on your behalf or do you have a Guardian ad Litem or similar legal representative acting on your behalf regarding this Evaluation Request & Potential Transaction?

Primary Insured: ☐ Yes ☐ No | 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.

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	Printed Name	Date
Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if not Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if not Insured)	Printed Name	Date

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NOTICE OF DISCLOSURE – MONTANA

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

1. There are possible alternatives to settlement contracts including but not limited to accelerated benefits offered by the life insurance company.
2. Some or all of the proceeds of the settlement may be taxable and assistance should be sought from a personal tax advisor. **Welcome Funds Inc** is not a tax advisor. Settlement brokers, providers or their respective employees or agents may not act as personal tax advisors.
3. Proceeds of the settlement could be subject to the claims of creditors.
4. The sale of the insurance policy may affect eligibility for Medicaid or other government benefits or entitlements. Advice on such effects should be obtained from the appropriate government agencies.
5. Montana law requires settlement contracts to allow the owner to rescind the contract not later than the 30th day after the date on which the contract is executed by all parties or not later the 15th day after the owner receives the proceeds, whichever is longer.
6. You have the right to know the date which the funds from the transaction will be available and the source of such funds. **Welcome Funds Inc.** has no access to or control over any settlement provider funds that are set aside in escrow or trust.
7. The settlement contract is void if the settlement provider or the settlement broker fails to pay the proceeds per the settlement contract.
8. Total compensation payable to the settlement broker(s) shall collectively not exceed a maximum of 8% of the face amount of the policy.
9. All medical, financial or personal information obtained by the settlement provider or the broker about the owner and the insured, including the owner's and the insured's identity or the identity of family members is confidential.
10. The medical, financial or personal information obtained by the settlement provider or the broker about the owner and the insured may not be disclosed in any form to any person, unless:
    a. disclosure is necessary to effect the settlement between the owner and the settlement provider.
    b. the owner and the insured have provided prior written consent to the disclosure.

    Such information may be provided to financing entities including individual and institutional purchasers.
11. I/we acknowledge that **Welcome Funds Inc.** has provided me/us with the Montana brochure, "What to Consider Before Selling Your Life Insurance Policy."

I/We acknowledge that I/we have read and understand the disclosures above (1-11).

Signature of **Policy Owner #1**	Printed Name	Date
Signature of **Policy Owner #2**	Printed Name	DatE
Signature of **Authorized Representative of Welcome Funds Inc.**	Printed Name	Date

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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

______________________________	______________________________
Life Insurance Company	**Policy Number**
______________________________	______________________________
Printed Name of All Policy Owner(s)	**Printed Name of Insured(s)**

By signing this release, I/we authorize the life insurance company named above and any other company or person that has information related to the life insurance policy named above to:

a) release such information to WELCOME FUNDS INC and its authorized representatives; and

b) reply immediately to any request for information or documents required by WELCOME FUNDS INC relating to the life insurance policy named above.

The information to be released includes but is not limited to the following:

a) original copy of the policy; b) applications for insurance; c) riders; d) current and projected illustrations; e) conversions; f) withdrawals; g) lapse or reinstatement coverage; h) verification of coverage; i) change in ownership and beneficiary; j) assignments; k) premium payments and payment provisions; l) contestable and suicide status; and m) any and all other information.

In addition, I/we authorize:

a) WELCOME FUNDS INC to share the information it receives with any other company or person for the purpose of evaluating all of my options related to the policy named above;

b) that this Authorization shall remain valid until (i) I/we withdraw our consent, pursuant to applicable law; or (ii) the death of the Insured (or if multiple Insureds, until the death of the last to survive), unless any applicable state statute or regulation requires a different time period. If a different time period is required, this Authorization shall remain valid for the maximum period allowed per state statute or regulation;

c) that a photocopy, PDF or electronic file or fax of this Authorization is as valid as an original.

Furthermore, I/we certify:

a) that this Authorization is being executed and delivered freely as of the date written below; and

b) understand the contents of this Authorization in full.

Authorized By:

______________________________	______________________________	__________
Signature of **Policy Owner #1**	Printed Name	Date
______________________________	______________________________	__________
Signature of **Policy Owner #2**	Printed Name	Date

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION PRIMARY INSURED ("Release")

I, ____ (Insured), _______________ (Date of Birth) __________________________ (SS #) authorize the disclosure to Welcome Funds Inc. ("WFI") of my protected health information as defined under the privacy regulations for all purposes of the Federal Health Insurance Portability and Accountability Act of 1996 ("1996 ACT") also known as HIPAA. I understand that my health information under this Release 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.

I. <u>The term, "WFI" shall include but not be limited to the following with respect to WFI under this Release</u>.
A. Its successors or assigns. B. Its agents and/or affiliates. C. Its officers. D. Its employees. E. Its subsidiaries and corporate parents. F. Its independent contractors or consultants. G. Its third party life expectancy and service providers. H. Its providers or financing sources (and any third party in connection with such financing). I. Other WFI authorized entities or authorized representatives and/or their agents. J. Other persons or entities needing to receive, evaluate, underwrite or solicit bids for a sale of any life insurance policy.

II. <u>Authorized parties who may release my medical records include the following (collectively, the "Directed Persons").</u>
A. Insurance companies. B. Medical Information Bureau. C. Any other institution or person with my medical records or information, including the following. 1. Physicians. 2. Doctors. 3. Physicians practice groups. 4. Nurses. 5. Pharmacies. 6. Clinics. 7. Medical centers. 8. Hospitals. 9. Any other health care provider. I acknowledge that Directed Persons shall be guided by instructions provided by WFI, as the request using this Release is as valid as if I had requested my own medical records.

III. <u>Medical records consist of all records concerning my past, present or future physical or mental history or condition as to diagnosis, treatment and/or prognosis ("Medical Records"). Medical Records include but are not limited to the following.</u>
A. X-rays. B. Charts. C. Medical Files/Records. D. Hospital records. E. Laboratory tests and results. F. Test and examination reports. G. Problem lists. H. Information relating to the following. a. Sexually transmitted diseases. b. Psychiatric evaluations, treatment and/or information. I. And any and all of my health and medical data and information and records. This Release shall also serve as my written consent to disclosure of drug, alcohol or HIV related information and medical records. Medical Records include but are not limited to private, privileged, protected or personal health information defined as "Protected Health Information" under this Release and the 1996 ACT whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

IV. <u>Authorized recipients of information from WFI under this Release may include the following but will not be limited to and can be used for the purpose listed below.</u>
A. medical underwriters. B. lenders. C. financing entities. D. brokers/brokerages. E. buyers of life insurance policies. F. life expectancy providers. G. stop-loss re-insurers. Each will include their. 1. affiliates. 2. agents. 3. subsidiaries. 4. corporate parents. 5. independent contractors. 6. consultants. 7. service providers. 8. authorized representatives. 9. officers. 10. directors. 11. employees. Each an ("Authorized Recipient"). This Release and all disclosures of my Medical Records made under this Release are for purposes of allowing the Authorized Recipient to. a. analyze. b. assess. c. evaluate or underwrite my health/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. As a result of this Release, my ongoing health status may be tracked by WFI or Authorized Recipient.

V. <u>Expiration of Release, right to remove Release, and additional items.</u>
This Release shall be valid until the Insured's death or the maximum time allowed by state or federal law. I understand that I may remove this Release at any time by notifying any Directed Persons in writing of my removal and by delivering the removal document by mail or personal delivery to any Directed Persons. I also understand that if Directed Persons have already released Medical Records that any removal of Release shall not cover that situation. This Release is not a consent or authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the 1996 Act. As a result of this Release, either of the following may occur with respect to Medical Records disclosed by the Directed Persons or other covered entity (as defined under the 1996 Act) to WFI. a. They may be redisclosed. b.They may no longer be protected by privacy laws provided by law, including but not limited to the 1996 Act.

I certify that I am executing this Release freely and unilaterally as of the date written below. This Release is written in plain language. I fully understand the contents of this Release. I had the opportunity to consult with an attorney prior to signing this Release. I agree that all Directed Persons can rely upon a fax or copy or other reproduction of this Release.

____
List of Directed Persons (Hospitals, Doctors, Etc.).

Authorized by.

______________________________	______________________	__________
Signature of **Individual** (Primary Insured).	Printed Name	Date
______________________________	______________________	__________
Signature of **Legal Representative** of Primary Insured (if any).	Printed Name	Date

Description of Legal Representative's **Authority** (if any). ______________________________________
(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION SECONDARY INSURED ("Release")

I, ____ (Insured), _______________ (Date of Birth) ___________________________ (SS #) authorize the disclosure to Welcome Funds Inc. ("WFI") of my protected health information as defined under the privacy regulations for all purposes of the Federal Health Insurance Portability and Accountability Act of 1996 ("1996 ACT") also known as HIPAA. I understand that my health information under this Release 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.

I. **<u>The term, "WFI" shall include but not be limited to the following with respect to WFI under this Release</u>**.
A. Its successors or assigns. B. Its agents and/or affiliates. C. Its officers. D. Its employees. E. Its subsidiaries and corporate parents. F. Its independent contractors or consultants. G. Its third party life expectancy and service providers. H. Its providers or financing sources (and any third party in connection with such financing). I. Other WFI authorized entities or authorized representatives and/or their agents. J. Other persons or entities needing to receive, evaluate, underwrite or solicit bids for a sale of any life insurance policy.

II. **<u>Authorized parties who may release my medical records include the following (collectively, the "Directed Persons").</u>**
A. Insurance companies. B. Medical Information Bureau. C. Any other institution or person with my medical records or information, including the following. 1. Physicians. 2. Doctors. 3. Physicians practice groups. 4. Nurses. 5. Pharmacies. 6. Clinics. 7. Medical centers. 8. Hospitals. 9. Any other health care provider. I acknowledge that Directed Persons shall be guided by instructions provided by WFI, as the request using this Release is as valid as if I had requested my own medical records.

III. **<u>Medical records consist of all records concerning my past, present or future physical or mental history or condition as to diagnosis, treatment and/or prognosis ("Medical Records"). Medical Records include but are not limited to the following.</u>**
A. X-rays. B. Charts. C. Medical Files/Records. D. Hospital records. E. Laboratory tests and results. F. Test and examination reports. G. Problem lists. H. Information relating to the following. a. Sexually transmitted diseases. b. Psychiatric evaluations, treatment and/or information. I. And any and all of my health and medical data and information and records. This Release shall also serve as my written consent to disclosure of drug, alcohol or HIV related information and medical records. Medical Records include but are not limited to private, privileged, protected or personal health information defined as "Protected Health Information" under this Release and the 1996 ACT whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations.

IV. **<u>Authorized recipients of information from WFI under this Release may include the following but will not be limited to and can be used for the purpose listed below.</u>**
A. medical underwriters. B. lenders. C. financing entities. D. brokers/brokerages. E. buyers of life insurance policies. F. life expectancy providers. G. stop-loss re-insurers. Each will include their. 1. affiliates. 2. agents. 3. subsidiaries. 4. corporate parents. 5. independent contractors. 6. consultants. 7. service providers. 8. authorized representatives. 9. officers. 10. directors. 11. employees. Each an ("Authorized Recipient"). This Release and all disclosures of my Medical Records made under this Release are for purposes of allowing the Authorized Recipient to. a. analyze. b. assess. c. evaluate or underwrite my health/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. As a result of this Release, my ongoing health status may be tracked by WFI or Authorized Recipient.

V. **<u>Expiration of Release, right to remove Release, and additional items.</u>**
This Release shall be valid until the Insured's death or the maximum time allowed by state or federal law. I understand that I may remove this Release at any time by notifying any Directed Persons in writing of my removal and by delivering the removal document by mail or personal delivery to any Directed Persons. I also understand that if Directed Persons have already released Medical Records that any removal of Release shall not cover that situation. This Release is not a consent or authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the 1996 Act. As a result of this Release, either of the following may occur with respect to Medical Records disclosed by the Directed Persons or other covered entity (as defined under the 1996 Act) to WFI. a. They may be redisclosed. b.They may no longer be protected by privacy laws provided by law, including but not limited to the 1996 Act.

I certify that I am executing this Release freely and unilaterally as of the date written below. This Release is written in plain language. I fully understand the contents of this Release. I had the opportunity to consult with an attorney prior to signing this Release. I agree that all Directed Persons can rely upon a fax or copy or other reproduction of this Release.

____

List of Directed Persons (Hospitals, Doctors, Etc.).

Authorized by.

________________________________ ________________________ __________

Signature of **Individual** (Primary Insured). Printed Name Date

________________________________ ________________________ __________

Signature of **Legal Representative** of Primary Insured (if any). Printed Name Date

Description of Legal Representative's **Authority** (if any). ____________________________________
(POA, Guardian ad Litem or similar status – Please attach legal documents for verification)

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WELCOME FUNDS

WELCOME FUNDS INC.
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BROKER AUTHORIZATION & SERVICES AGREEMENT

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

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

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

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

WELCOME FUNDS INC represents the best interests of consumers in an effort to obtain one or more offers for the sale of their policy(ies). As your designated broker, WELCOME FUNDS INC incurs the necessary, required and related costs to facilitate a life settlement while providing the following services, including but not limited to:

- Qualification analysis and review
- Evaluation Form assessment
- Submission to one or more life settlement providers
- Medical underwriting & insurance verifications
- Closing services including contract review & assistance with requirements of life settlement providers

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 related to the purchase of the following life insurance policy(ies):

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

By signing this Authorization and Agreement, I/we am/are:

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

Agreed to & Accepted by:

Signature of **Policy Owner #1**	Printed Name	Date
Signature of **Policy Owner #2**	Printed Name	Date
Signature of **Authorized Representative of WELCOME FUNDS INC.**	Printed Name	Date

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MONTANA STATE AUDITOR

Monica Lindeen
State Auditor

Commissioner of Insurance
Commissioner of Securities

WHAT TO CONSIDER BEFORE SELLING YOUR LIFE INSURANCE POLICY

VIATICAL SETTLEMENTS

Selling a life insurance policy may not always be in your best interest. There are many things to consider before doing so. The following will give you the basic information you need to make an informed decision. Even with this information, it is important for you to consult with your legal and financial advisors before making the decision to sell your policy.

WHAT IS A VIATICAL SETTLEMENT?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (**viator**) of the life insurance policy sells the policy for an immediate cash benefit. The **viator** will enter into a contract with the viatical settlement provider (**provider**) to accept a cash payment in exchange for the life insurance policy. The cash payment will be less than the face amount of the policy which would be paid upon the death of the insured.

As a result of the transaction, the **provider** will:

- become the new owner of the insurance policy
- pay any future premiums
- name the beneficiary
- collect the benefits upon the death of the insured
- and may sell your policy again

QUESTIONS TO ASK

- **Do I still need life insurance protection?** Have your needs for life insurance changed since you bought the life insurance policy? If not, selling your policy may not be the right choice. If you sell your life insurance policy now, your beneficiaries will not receive a benefit at the time of your death. Life insurance premiums increase as you grow older. You may not want to pay the higher cost for coverage in the future. If your health changes, you may no longer qualify to purchase life insurance.

Phone 1-800-332-6148 / (406) 444-2040 / Fax: (406) 444-3497
840 Helena Avenue, Helena, MT 59601 Website: sao.state.mt.us E-mail: stateauditor@state.mt.us

- **What other options may be available to me?** Check with your insurance producer or company to determine if any of the following options are available to you.

    - **Surrendering the policy for the current cash value**
    - **Borrowing against the cash value.** This will allow the policyholder to keep the policy in force. The benefits of the policy will be reduced by the amount of the loan outstanding and any accumulation of interest due to the insurance company.
    - **Using the cash value as collateral to obtain a loan from a financial institution.**
    - **Accelerated death benefit provisions.** Many life insurance policies have an accelerated death benefit provision. This provision may allow an insured who is terminally ill or permanently confined in a nursing home to receive a portion of the face value of the policy while the insured is still living. The policy remains in force which means that when the insured dies, the balance of the benefits will be paid to the beneficiaries.

- **If the policy is through an employer or another group, do I need permission to sell it?**
- **If I sell the policy, who will become the owner and collect the death benefits?**
- **Will the sale of the life insurance policy affect my income taxes, estate planning or my eligibility for public assistance benefits such as Medicaid or other government benefits?**
- **If I sell the policy, can my creditors claim the money?**
- **Who will have access to information about my health and financial records?**
- **After the sale of the life insurance is complete, can it be resold by the buyer?**
- **If I decide to sell the policy, how is the purchase price determined?**
- **If I wait a year or two before selling the policy, will the purchase price increase?**

HOW DOES THE SETTLEMENT TRANSACTION WORK?

The sale is usually arranged through a viatical settlement broker (**broker**). Regardless of how the **broker** is compensated, the **broker** is required by law to represent only the **viator** and owes a fiduciary duty to the **viator** to act according to the **viator's** instructions and in the best interests of the **viator**. The **viator** should ask the **broker** about the business relationship between the **broker** and the **provider** before the transaction is finalized. In many cases, the **broker** is paid a commission from the **viator's** proceeds of the sale of the policy.

The **provider** will need information about the insured before they will be able to make an offer to purchase the policy. The **provider** will request a medical release form so they can receive and review the insured's medical records. They will also require an authorization form to contact the insurance company to confirm the ownership of the policy, the benefits and premiums.

The **provider** will use the information collected to make an offer. There are many factors that the **provider** will take into account in order to determine the offer. Some of those may include:

- Amount of life insurance coverage
- Medical condition and estimated life expectancy of the insured.
- Any loans outstanding against the policy
- The premiums required to keep the policy in force

If you accept the offer, there will be additional forms sent to you by the **provider**. These forms will be necessary to complete the change of ownership of the policy and will stipulate the conditions of the sale of the policy. Once these forms are completed and returned to the **provider**, the **provider** will forward the necessary paperwork to the insurance company to record the changes. At this time, the **provider** will also place the proceeds owed to you (**the viator**) in an independent escrow account to protect your funds during the completion of the transfer of the policy.

Once the insurance company notifies the **provider** that the requested changes to the policy have been recorded, the proceeds will be released to the **viator**.

Montana code requires viatical settlement contracts contain a provision enabling the **viator** to rescind the contract not later than the 30th day after the date on which the contract is executed by all parties or not later than the 15th day after the **viator** receives the viatical settlement proceeds, whichever is the longer period.

PERSONAL INFORMATION

The **provider** will periodically inquire about the health status of the insured. The **provider** is permitted to share the insured's non-public health information with persons or entities that are involved in the viatical settlement transaction. The **provider** may resell the policy as an investment to third parties. Those third parties will also have access to the health records of the insured.

CONSUMER TIPS

- Compare the services provided and fees charged by several **brokers** before entering into an agreement.
- Get quotes from several **providers** to determine if the offers to purchase the policy are competitive.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- Consult a tax professional to determine if the proceeds from the sale of the policy are taxable under federal and state income tax.
- Consult legal and financial professionals to determine if the proceeds from the sale of the policy are subject to the claims of creditors, personal representative, trustees in bankruptcy, and receivers in state and federal courts.
- Consult with your insurance company because the change of ownership could limit your ability to purchase life insurance in the future because there is a limit to how much coverage insurers will issue on one life.
- Under normal circumstances, a **broker** or **provider** will not be able to provide any guidance on tax implications, financial implications, or federal and state governmental benefits.
- Check all contract and application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Be sure to read all portions of the contract and application. Consult with a legal professional to be sure the provisions are in your best interest.
- Call the Montana Insurance Commissioner's Office to verify the **broker** and **provider** are licensed to do business in the State of Montana.

REMEMBER, SELLING A LIFE INSURANCE POLICY MAY NOT ALWAYS BE IN YOUR BEST INTEREST. PLEASE CONSIDER ALL OF YOUR OPTIONS PRIOR TO ENTERING INTO A VIATICAL SETTLEMENT CONTRACT.