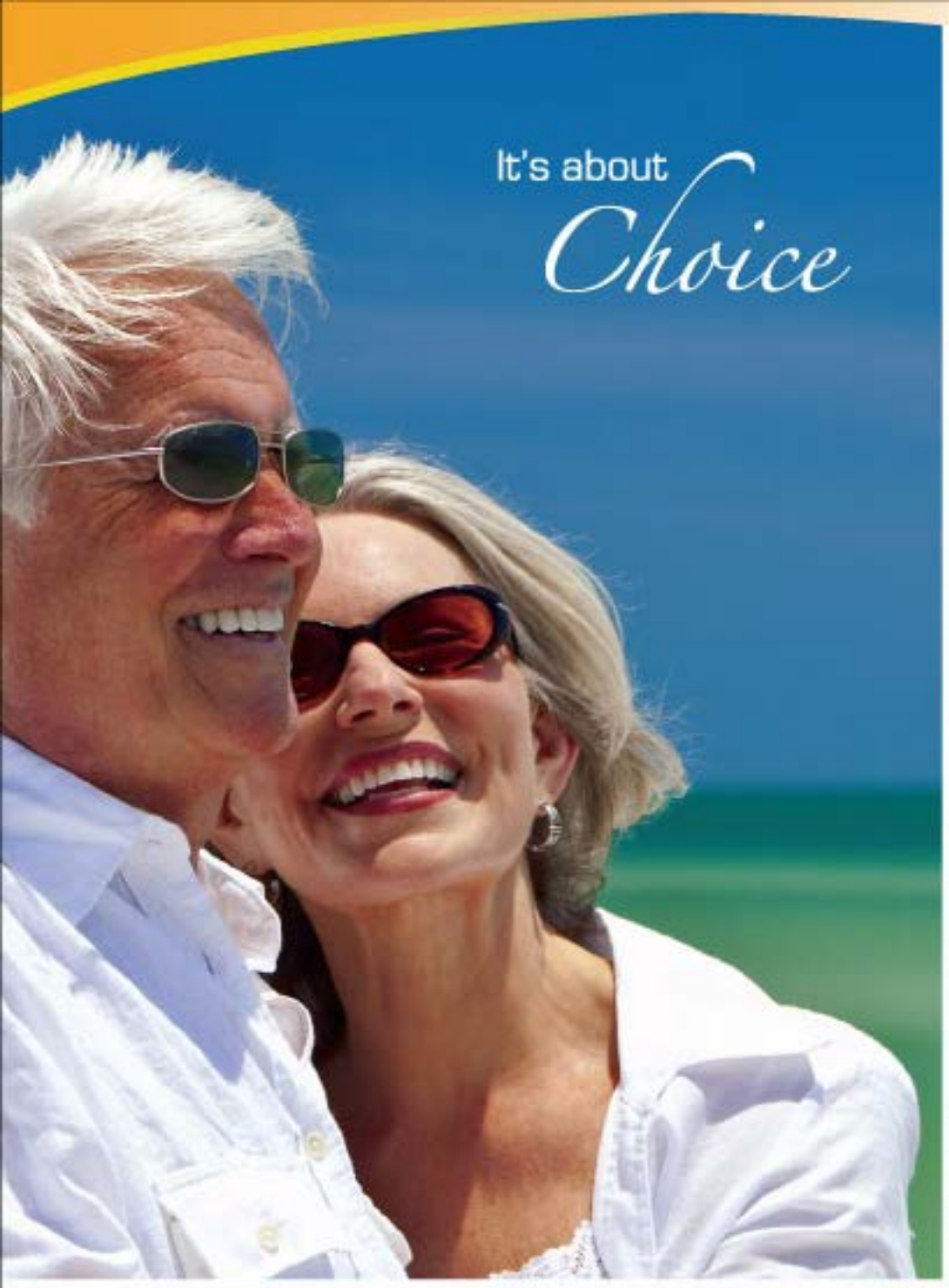

STATE OF OREGON

1859

WELCOME FUNDS

Life Settlements. Simplified.®

OREGON 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 Oregon

Life Settlement Broker License

State of Oregon

License No: 100165207

Insurance License

Oregon Department of Consumer & Business Services Insurance Division

WELCOME FUNDS INC

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

NON-RESIDENT

LICENSE TYPE	LICENSE EFFECTIVE DATE	LICENSE EXPIRATION DATE	LINES OF AUTHORITY
Life Settlement Broker	04/01/2023	03/31/2025	

The license continues in force until it is suspended, revoked, or expired. This license cannot be reinstated if it has been expired longer than 1 calendar year from the date of expiration.

A licensee must notify the director of the Department of Consumer Services & Business Services no more than 30 days after a change of resident, business address, or telephone number. ORS-744.068

A producer can not transact insurance unless appointed by an insurer or affiliated with a business entity that is appointed by an insurer. ORS 744.078

For more information, call (503)947-7981

Register for E-notify to receive notification of law changes; The Regulator, and other information.

https://service/gov/delivery.com/service/multi_subscribe.html

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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?**

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

ADDITIONAL INFORMATION

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

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

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

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

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

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

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

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

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

ESTIMATED INSURABLE CAPACITY FOR INSURED(S): $_____

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

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

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

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

INDIVIDUALS:

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

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

ENTITIES:

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

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

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

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

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

Verified and Confirmed By:

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

PERSONAL ACKNOWLEDGEMENTS

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

☐ Yes ☐ No

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

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

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

Primary Insured: ☐ Yes ☐ No
Secondary Insured (if applicable): ☐ Yes ☐ No
Policy Owner #1: (if not Insured): ☐ Yes ☐ No
Policy Owner #2 (if applicable): ☐ Yes ☐ No

If Yes, then please 1) attach the applicable legal documents to this Evaluation Request; 2) have the legal representative of the insured sign the "Authorization for Disclosure of Protected Health Information" forms for the primary and secondary insured as applicable; and 3) provide the names of such legal representative(s) below:

Name of **Legal Representative of Primary Insured** (if applicable) | Name of **Legal Representative of Policy Owner #1** (if applicable)

Name of **Legal Representative of Secondary Insured** (if applicable) | Name of **Legal Representative of Policy Owner #2** (if applicable)

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

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

IV. Was this insurance policy premium financed?

☐ Yes ☐ No

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

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

I/We represent that the information contained in this Evaluation Request for Sale of Existing Life Insurance is correct and accurate and acknowledge that WELCOME FUNDS INC may rely on such information, including but not limited to the Personal Acknowledgements above. I/we will immediately notify WELCOME FUNDS INC of any changes.

I/We give my/our consent to WELCOME FUNDS INC, its agents and/or authorized representatives to release and/or transmit electronically all financial and insurance information gathered from this Evaluation Request for Sale of Existing Life Insurance, including but not limited to medical records, notes and lab reports pertaining to the insured's health, to the appropriate parties who have an identifiable need to facilitate the sale of my/our life insurance policy.

I/We further acknowledge that this Evaluation Request for Sale of Existing Life Insurance may become part of my contract for the sale of my existing life insurance policy if my/our life insurance policy is purchased. In addition, I/we have been advised that I/we may obtain a copy, upon request, of any written agreement that I/we enter into regarding or relating to the sale of my/our life insurance policy(ies).

Acknowledged By:

Signature of **Primary Insured** | Printed Name | Date

Signature of **Secondary Insured** (if applicable) | Printed Name | Date

Signature of **Policy Owner #1** (if not Insured) | Printed Name | Date

Signature of **Policy Owner #2** (if not Insured) | Printed Name | Date

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

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NOTICE OF DISCLOSURE (PAGE 1 OF 2)

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

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

2. Some or all of the proceeds of your life settlement may be taxable under federal & state income tax laws. **Welcome Funds Inc** is not a tax advisor & recommends that assistance be sought from a professional tax advisor regarding this transaction.

3. Receipt of proceeds from a life settlement contract may a) affect your eligibility for public assistance or other government benefits or entitlements, and advice should be obtained from the appropriate agencies; and b) reduce your risk of becoming impoverished and becoming dependent on public assistance or other government benefits or entitlements.

4. Life settlement proceeds may 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 &/or an attorney regarding these potential alternatives.

6. You have the right to rescind (terminate) the life settlement contract before the earlier of sixty (60) calendar days after the date upon which the life settlement contract is executed by all parties or thirty (30) calendar days after the life settlement proceeds have been paid, as provided by Oregon law. Rescission, if exercised, is effective only if both notice of rescission is given & repayment of all proceeds & any premiums, loans & loan interest paid on account of the life settlement within the rescission period occurs. If the insured dies during the rescission period, then the life settlement contract shall be deemed rescinded, subject to repayment by you or your estate of all life settlement proceeds and any premiums, loans & loan interest of the life settlement within sixty (60) days of the insured's death.

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

8. Entering into a life settlement contract may prevent the owner from qualifying for new life insurance coverage in the future and may cause other rights or benefits, including conversion rights & waiver of premium benefits that may exist under the policy or certificate, to be forfeited. Assistance should be sought from a professional financial advisor.

[Additional Disclosures on Next Page]

NOTICE OF DISCLOSURE (PAGE 2 OF 2)

9. Total compensation payable to **Welcome Funds Inc** & 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 life settlement provider reduced by the total compensation as described above. Actual compensation shall be disclosed no later than the life settlement contract is signed by all parties.

10. All medical, financial or personal information solicited or obtained by a life settlement provider or **Welcome Funds Inc** 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 contract between you & 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. In addition, information regarding the policy owner's & insured's identity & insured's medical condition will 1) be shared with the insurer that issued the life insurance policy; & 2) shall be available to each subsequent owner of the life insurance policy.

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 by Oregon law. This contact is limited to no more frequently than once every three (3) months if the insured has a life expectancy of more than one (1) year, & 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 in which the policy owner resided at the time of the life settlement, or by the authorized representative of a duly licensed life settlement provider.

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

13. I/we confirm & acknowledge that **Welcome Funds Inc** has provided me/us with a brochure issued by the Insurance Division of the Oregon Department of Consumer & Business Services titled, "Thinking about selling your life insurance policy?"

I/We acknowledge that I/we have read & understand the disclosures above (1-13).

Signature of **Primary Insured**	Printed Name	Date
Signature of **Secondary Insured** (if applicable)	Printed Name	Date
Signature of **Policy Owner #1** (if not Insured)	Printed Name	Date
Signature of **Policy Owner #2** (if not Insured)	Printed Name	Date
Signature of **Authorized Representative of Welcome Funds Inc**	Printed Name	Date

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AUTHORIZATION FOR THE RELEASE OF LIFE INSURANCE POLICY INFORMATION

Life Insurance Company _____

Policy Number _____

Printed Name of All Policy Owner(s) _____

Printed Name of Insured(s) _____

I/we (the undersigned individual(s)) hereby authorize the above-referenced life insurance company and/or any other entity or person that has information related to the above-referenced life insurance policy to release such information to and reply immediately to any written, telephonic or other request for information or documents required by WELCOME FUNDS INC and/or its authorized representatives pertaining to the above-referenced life insurance policy that I/we own.

I/we understand and specifically authorize the release of information by this form to include any and all LIFE INSURANCE POLICY OR CERTIFICATE information, including but not limited to: *applications for insurance, forms, riders, illustrations, conversions, current values, verification of coverage, contestable and suicide status, lapse or reinstatement application and history and amendments concerning the policy or certificate, 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)

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ (the undersigned individual), DOB_____SS#_____, hereby authorize disclosure, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, of my protected health information ("PHI") as follows:

1. **Classes of Persons Authorized to Disclose My PHI.** I authorize each doctor, hospital, laboratory, nurse, pharmacy, pharmacy benefits manager, physician, physician practice group, clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. **Classes of Persons Authorized to Receive My PHI.** I authorize each Authorized HCP to disclose my PHI under this authorization to **Welcome Funds Inc** including a) any of its affiliates, employees, agents, independent contractors, service providers and authorized representatives; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, facilitate, monitor, underwrite and solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, buyers of life insurance policies, life expectancy providers, brokers/brokerages and its or their respective affiliates, employees, agents, independent contractors, service providers and authorized representatives (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
3. **Description of PHI Authorized for Disclosure and Purpose of Disclosure.** This authorization shall apply to any and all of my health, genetic and medical data, evaluations, notes, treatments, prescriptions, lab results, diagnosis, diagnostic testing, information, recommendations, reports and records (collectively, "Data"), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing an Authorized Recipient to a) monitor, track, verify, analyze, assess, evaluate and/or underwrite my health or medical status/condition or life expectancy, including without limitation, in connection with the possible sale of any life insurance policy, annuity or certificate of life insurance under which my life is insured; and b) track and develop mortality and longevity trends and products. I acknowledge that some state and federal laws prohibit/may prohibit the disclosure of Data related to mental/emotional health conditions, psychiatric treatment, substance abuse (drugs, alcohol, medications etc), or HIV related and/or communicable/sexually transmitted disease information without specific written consent. This authorization serves as specific consent a) for such disclosure to occur; b) for each Authorized Recipient to perform the functions described herein; and c) to include Data that is created before and after the date this authorization is signed, up until its expiration or revocation date.
4. **Expiration of Authorization.** This authorization shall remain valid until, and shall expire, one year after the date of my death.
5. **Right to Revoke Authorization.** I acknowledge and understand that I may revoke this authorization at any time via written notification by mail or personal delivery to **Welcome Funds Inc** at 4755 Technology Way, Suite 202, Boca Raton, FL 33431, with respect to **Welcome Funds Inc**; and to any Authorized HCP at the address designated to me by such Authorized HCP, with respect to such Authorized HCP. I further acknowledge that any revocation of this authorization, with respect to **Welcome Funds Inc** and/or any Authorized HCP, shall not apply to the extent that **Welcome Funds Inc** and/or any Authorized HCP, as applicable, has acted in reliance upon this authorization prior to receiving written notice of my revocation.
6. **Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that a) this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA"); b) as a result of this Authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA or other privacy laws and regulations; and c) my ongoing health status may be tracked as a result of this Authorization.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

_____

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

Authorized by:

_____ _____ _____
Signature of **Individual** (Second Insured) Printed Name Date

_____ _____ _____
Signature of **Legal Representative** of Second Insured (if any) Printed Name Date

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

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

BROKER AUTHORIZATION & SERVICES AGREEMENT

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

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

_____ _____

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

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

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

In consideration of the services provided and related costs incurred as described above, I/We authorize WELCOME FUNDS INC to act as my/our 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 _____. 2nd Policy No. _____ issued by _____.
Name of Insurance Carrier (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, 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 business model, methods and practices, for the sale of my/our life insurance policy(ies) as stated above.
2. Recognizing the proprietary nature of such appropriate, conditional offers as evaluated, underwritten, solicited, generated and secured by WELCOME FUNDS INC for the period of time as described above and pursuant to this Broker Authorization & Services Agreement.
3. Agreeing to the total compensation, as described in this paragraph, payable to WELCOME FUNDS INC and your referring advisor/broker, if any. Such total compensation shall collectively not exceed a maximum of 8% of the Net Death Benefit (NDB) of your policy. Proceeds from the sale of your life insurance policy are represented by the Net Purchase Price (NPP) as follows: NPP = Gross Purchase Price (GPP) as paid by the buyer of the policy reduced by the total compensation as described in this paragraph.
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 Officer of WELCOME FUNDS INC**	Printed Name	Date

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Thinking about selling your life insurance policy?

December 2009

INSURANCE *Tips*

Life insurance is a critical part of a broader financial plan. There are many options available. Seek advice from different financial advisers to find the option best suited to your needs.

What are life settlements?

A life settlement is the sale of your life insurance policy to a third party for a cash amount that is less than the full death benefit. The buyer becomes the new owner and/or the beneficiary of the life insurance policy, pays all future premiums, and collects the entire death benefit when you die.

Before you sell your life insurance, ask:

- Do I still need my insurance?
- Have I discussed all my choices with my financial adviser and my insurance company or agent? For example: Do I have cash value in my policy that I can use to pay premiums or an accelerated death benefit? Can I get a loan to pay premiums, or will my beneficiaries help with making premium payments to protect their interest?
- Will this limit my ability to buy additional life insurance in the future?
- If I sell my policy, how much cash will I get?
- Does an employer or other group policy provide my life insurance? Can I sell my policy? Am I really the owner or just a certificate holder in a group policy?
- If I sell my policy, who will be the legal owner? Will the policy be resold?
- If my policy is resold, what personal or medical information can be shared with the purchasers? How often will they request my medical information? Will I be required to sign releases allowing them to contact my medical providers or family members for my health information?
- Is the broker or company I plan to work with licensed to do business in Oregon?

If you sell your life insurance, know that:

- You may have to pay state/federal income taxes on some or all of your settlement money. It is important to consult a tax professional.
- Creditors may be able to make claims on the proceeds from your life settlement.
- A cash settlement may affect your eligibility for some government programs, such as food stamps or Medicaid.
- Your policy could be resold multiple times and future owners may have the ability to track your health.

How do life settlements work?

- You can contact life settlement companies directly or choose a broker to help you shop for the highest cash settlement.

Free help

with your insurance questions or complaints

Consumer Advocacy Hotline

Toll-free
1-888-877-4894

Salem
503-947-7984

E-mail
cp.ins@state.or.us

Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Phone: 503-947-7980
Fax: 503-378-4351
Web: insurance.oregon.gov

Continued to next page

- You complete an application and sign a release allowing the potential buyer to use your medical records to evaluate your life expectancy.
- You select the best offer.
- Once you accept an offer, an escrow account is set up. The account holds the purchaser's money and your life insurance policy until the documents that change ownership of the policy and the beneficiary have been received and processed by the insurance company. This protects you and the buyer of your life insurance.
- You will get your cash within three business days after the life settlement company gets written proof that the changes in policy ownership and beneficiary have been processed by the life insurance company.
- You can change your mind about the settlement within 60 days from the date of the life settlement contract or 30 days after you are paid, whichever is earlier. If you cancel the settlement, you must return the cash settlement plus any premiums the buyer paid. If you die within this period, the life settlement sale is off. Your beneficiaries receive the death benefit. They must return any cash settlement funds received plus any premiums the buyer paid.
- Your contract may require you to allow future owners of your policy to regularly contact you to check your health status.

Tips if you sell your policy

- Decide whether to sell your policy directly to a life settlement provider or go through a life settlement broker who will shop for you. If you don't use a life settlement broker, you should contact more than one company.
- You do not have to accept any life settlement offer. It is your contract; you decide what to do with it. It may be worth more if sold when you are older.
- If you learn that you are terminally ill, your estate (instead of investors) could benefit from the tax-free death benefit provided by life insurance. Proceeds from the life settlement sales are taxable. Contact your tax adviser for details.
- If you are terminally or chronically ill, Oregon law requires that buyers of your policy pay you a minimum amount based on your life expectancy and the face value of your policy. Contact the Insurance Division toll-free at 1-888-877-4894 to learn more.
- If you do sell your policy, check all application forms for accuracy, especially personal and medical information that you provide. Answer all questions truthfully.

Stranger-originated life insurance

Contact the Oregon Insurance Division if you are offered any money or gift to purchase insurance, or if you are offered free insurance for a period of time. Call if you are asked to purchase insurance for the purpose of selling it to investors. You can reach an advocate at 503-947-7984 or toll-free at 1-888-877-4894.

Warning about loans to buy life insurance

- Be wary of offers to loan you money to buy life insurance. For example, someone may offer you "free life insurance" for five years. Find out what strings are attached. What happens after the five years?
- Will you have to repay the loan with interest to keep the policy for your beneficiary? Are there tax consequences if the loan is pardoned?
- If you can't pay back the loan, will someone else own your life insurance and get the death benefit? Can you cancel the policy? Will you still have to pay back the loan payments?
- Will the lender have rights to part of the death benefit as collateral for the loan?

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Questions or complaints?

Call the Oregon Insurance Division consumer advocates at 503-947-7984 or toll-free at 1-888-877-4894. You can also e-mail: cp.ins@state.or.us

Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Phone: 503-947-7980
Fax: 503-378-4351
Web: insurance.oregon.gov

440-4845-11 (12/09/COM)