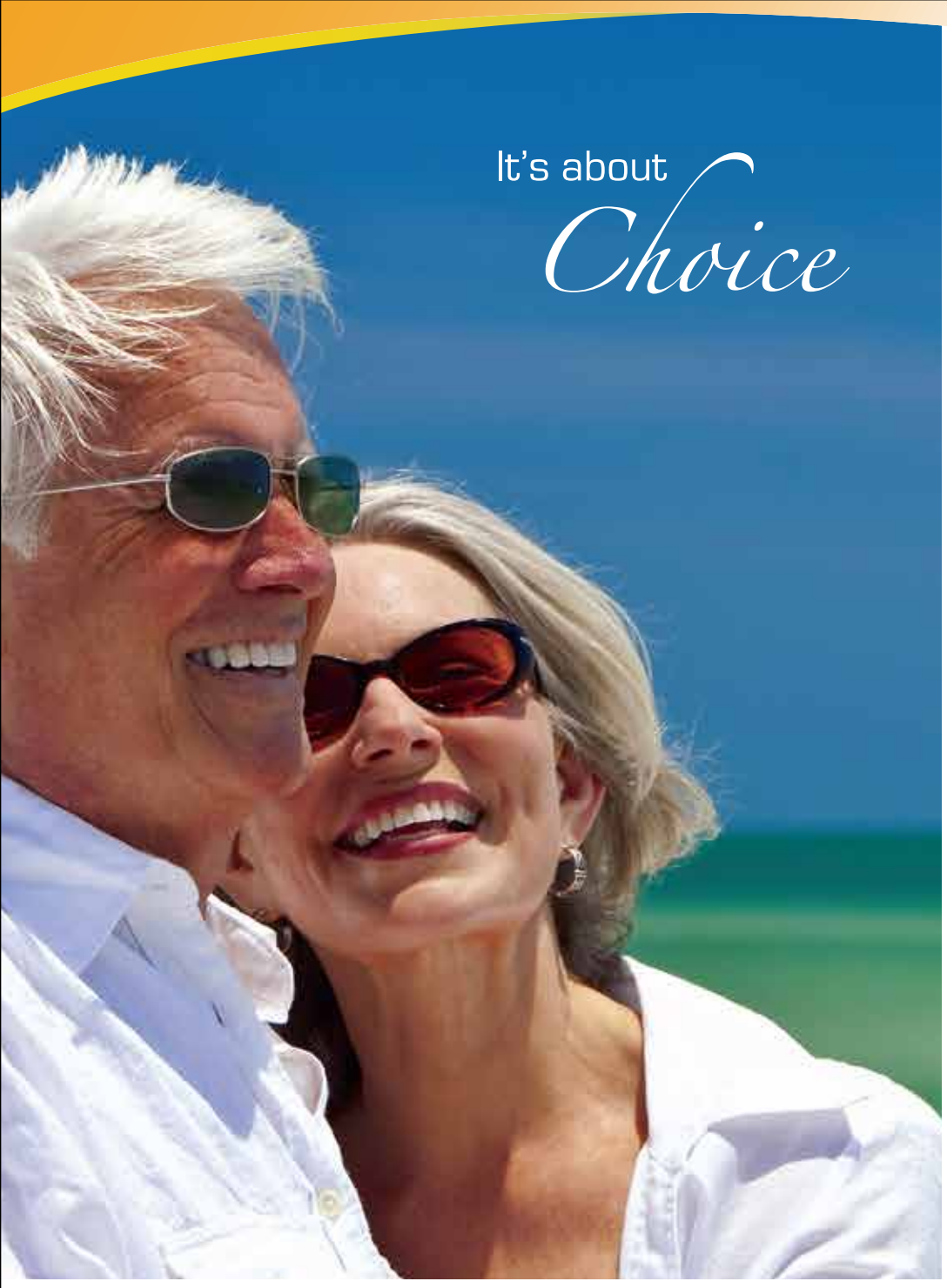

WELCOME FUNDS

Life Settlements. Simplified.®

PENNSYLVANIA 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 Pennsylvania

Viatical Settlement Broker License

WELCOME FUNDS INC
License Number 64099

is licensed to engage in the business of insurance in the Commonwealth of Pennsylvania in the capacity stated below, subject to applicable laws and rules

License Type: Non-Res Viatical Settl Broker

Effective Date: May 20, 2004
Expiration Date: May 20, 2025

WELCOME FUNDS INC
4755 TECHNOLOGY WAY
BOCA RATON, FL 33431

Lines of Authority:

4132143114

WELCOME FUNDS INC.
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LETTER FROM THE PRESIDENT

Dear Policy Owner/Insured:

Thank you for choosing WELCOME FUNDS INC to help you determine and identify the merits and value of selling your policy. We understand that the process can be intimidating and overwhelming and it is our job to not only maximize the sales value of your policy(ies) in the secondary market, but also to provide a seamless, transparent and fully informed experience. Please complete our Evaluation Request for Sale of Existing Life Insurance and sign the appropriate pages.

As your designated broker who represents your best interests and follows your instructions, WELCOME FUNDS INC incurs the necessary, required and related costs to facilitate the potential sale of your policy related to the following services:

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

Please read the Notice of Disclosure and the Broker Authorization and Services Agreement carefully and sign accordingly. These pages represent the first step in explaining your rights and obligations associated with the process. With that said, you are under no obligation to accept any contingent offers secured by WELCOME FUNDS INC. Furthermore, we have attached a brief brochure issued by the Pennsylvania Insurance Department titled, “Your Guide to Viatical Settlements” to read and review as well.

Please be advised that the personal information acquired shall only be shared with individuals and entities with an identifiable need to help determine the market value of your policy, including but not limited to life expectancy underwriters and potential buyers of your policy. All parties involved in the analysis, evaluation, underwriting and contingent pricing for transactions are required to maintain strict privacy and confidentiality safeguards pursuant to applicable state and federal regulations.

Once again thank you for allowing us the opportunity to help you reach your financial goals and to represent you in the secondary market for the potential sale of your life insurance policy.

Sincerely,

John M. Welcom
President

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EVALUATION REQUEST FOR SALE OF EXISTING LIFE INSURANCE

Fraud Warning: Any person who knowingly and with intent to defraud another presents or causes to be presented any statement forming a part of or in support of an application for insurance or viatical settlement contract any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, commits a fraudulent viatical settlement act and is subject to civil and criminal penalties.

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

PRIMARY INSURED'S PERSONAL INFORMATION

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

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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

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

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

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

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

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

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

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

CURRENT HOME ADDRESS | **TELEPHONE NUMBER**

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

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

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

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

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

PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY

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

PLEASE CHECK APPICABLE RELATIONSHIP TO PRIMARY INSURED (IF APPLICABLE)

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

LIFE INSURANCE POLICY INFORMATION

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

FACE AMOUNT | **TOTAL POLICY LOAN AMOUNT** | **CASH SURRENDER VALUE**

☐ Individual ☐ Joint Survivorship ☐ Group ☐ Other_____

TYPE OF POLICY (PLEASE CHECK ONE)

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

☐ Term ☐ WL ☐ UL ☐ Other:_____

CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly $_____

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

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

ADDITIONAL BENEFICIARIES AND/OR CONTINGENT BENEFICIARIES

POLICY OWNER INFORMATION

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

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

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

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

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

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

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

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

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

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

☐ YES ☐ NO ☐ YES ☐ NO Date:_____

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

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

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

Fraud Warning: Any person who knowingly and with intent to defraud another presents or causes to be presented any statement forming a part of or in support of an application for insurance or viatical settlement contract any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, commits a fraudulent viatical settlement act and is subject to civil and criminal penalties.

1. WELCOME FUNDS INC and your referring advisor/broker, if any, represents only you and shall 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. You have the unconditional right to rescind the viatical/life settlement contract for thirty (30) days from the date of the contract and at least fifteen (15) calendar days from receipt of the settlement proceeds. If the insured dies during the rescission period, then the settlement contract shall be deemed rescinded, subject to repayment of all settlement proceeds.
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. Actual total compensation shall be disclosed no later than the date all required parties have signed the viatical/life settlement contract.
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 its authorized representative 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 (1) year, and no more than once per month if the insured has a life expectancy of one (1) year or less.
12. WELCOME FUNDS INC recommends that you read the viatical/life settlement contract and seek assistance from a professional financial or legal advisor prior to signing it.
13. I/we acknowledge that WELCOME FUNDS INC has provided me/us with the Pennsylvania Insurance Department's brochure titled, "Your Guide to Viatical Settlements."

I/We acknowledge that I/we have read and understand the disclosures (1-13) and the fraud warning 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 not Insured)	Printed Name	Date
Signature of **Authorized Officer 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)

INSURANCE FACTS
for Pennsylvania Consumers

Your Guide to
Viatical Settlements

1-877-881-6388
Toll-free Automated *Consumer Line*

www.insurance.state.pa.us
Pennsylvania Insurance Department Website

What is a Viatical?

Viatical settlements (also called "life settlements") are agreements in which a life insurance policyholder assigns the ownership of the policy to a **viatical settlement provider** in exchange for a percentage of the policy's face value.

In other words, it is the sale of a life insurance policy to a third party. The owner sells the policy for a cash payment that is less than the full amount of the death benefit.

The provider continues to pay the policy premiums and upon the policyholder's death, cashes in on the policy for its full amount.

In order to fund the transaction, the provider seeks viatical settlement purchasers, who are investors that provide the money needed to buy the life insurance policies. These investors ultimately share in the proceeds from the policies.

Regulation of Viaticals

Under Pennsylvania's Viatical Settlments Act, the Pennsylvania Insurance Department regulates the sale and solicitation of viatical settlement contracts as of January, 2003. The Pennsylvania Securities Commission regulates all investments in viatical settlements.

In its new role, the Insurance Department will regulate all viatical settlement contracts; as well as license viatical settlement providers and bokers.

This Act also provides several important safeguards for consumers who choose to sell life insurance policies by entering into a viatical settlement, and includes requirements aimed at preventing fraud from occurring in these transactions

The Act Provides:

General rules for viatical settlements, including a requirement that the viator consents to the contract, is of sound mind, and is not under constraint or undue influence.

A requirement that viatical settlement providers and brokers keep the identity of the insured and their financial and medical information confidential (except in specified circumstances). Where disclosure of the information is permitted, the viatical settlement provider or broker must obtain the consent of the viator and the insured.

A requirement that viatical settlement providers and brokers be licensed by the Pennsylvania Insurance Department, and once licensed, a requirement that they remain "worthy" of licensure.

A requirement that all viators receive certain disclosures, including this brochure, before completing the viatical settlement transaction.

The disclosure of all commissions that a viatical settlement broker would receive as a result of the viatical settlement contract.

The viator has a right to reverse the viatical settlement transaction for 15 days from the receipt of the viatical settlement payment and an automatic reversal of the transaction if the insured dies within that 15 day period.

An explanation of the methods used by the viatical settlement provider to track the health status of the insured and limitation on the number of times that the insured can be contacted for health status inquiries.

CONSUMER ALERT

Be cautious if you are:

· interested in selling your life insurance policy and want more information; or

· contacted by someone who wants you to buy a life insurance policy and then immediately sell that policy in a viatical settlement transaction.

Know your Options and Understand the Facts

Entering into a viatical settlement contract is an important financial transaction. The decision to viaticate your life insurance policy should be made only after a thorough consideration of your unique financial needs and your personal situation. If you're thinking of entering into a viatical settlement you should:

- Be sure that the viatical settlement broker and the viatical settlement provider that you are dealing with are licensed by the Pennsylvania Insurance Department. You may ask to see their license or contact the Department. Also, ask for references in order to determine if the broker and provider are reputable.
- Consult your own professional financial advisor who knows your personal financial circumstances, investment objectives, age, and other considerations in order to determine whether a viatical settlement is right for you.
- Ask your tax advisor about any possible tax consequences of entering into a viatical settlement. In most situations, your receipt of the viatical settlement payment for selling your life insurance policy is subject to tax.
- Consult your insurance agent or life insurance company in order to determine what options you have under your life insurance policy that will provide you with immediate access to funds.
- Determine whether your receipt of the viatical settlement payment will affect your eligibility for Medicaid or other government benefits or entitlements. You should obtain advice from the government agencies that administer the benefits that you currently receive.
- Request that your viatical settlement broker "shop" your life insurance policy with multiple viatical settlement providers, and ask to see the offers from each of the providers, as well as, the commissions that the broker will receive for each of those offers.
- Ask questions. If you don't understand any part of the process or the contract, ask the viatical settlement broker or provider for an explanation. Also, you do not have to accept any offer made by the provider.

Some Definitions

Viatical settlement: the sale of a life insurance policy to a third party.

Viator: the owner of the life insurance policy, who sells the policy for a percentage of the death benefit.

Insured: the person whose life is covered by the life insurance policy. The insured may or may not be the same person as the viator.

Viatical settlement provider: the person or company that manages the viatical settlement transaction and makes offers to buy life insurance policies from viators.

Viatical settlement broker: the person or company that represents the viator in a viatical settlement. The viatical settlement broker is to always act in the best interest of the viator and is responsible for "shopping" the life insurance policy with viatical settlement providers in order to obtain the best deal for the viator.

The Pennsylvania Insurance Department is here to help with questions, comments or concerns. The Department's toll-free automated consumer hotline at 1-877-881-6388 is staffed Monday through Friday from 8 a.m. to 4:30 p.m. Consumers can also contact the Harrisburg Regional Office at **(717) 787-2317**.

Questions about investmens in viatical settlements should be directed to the Pennsylvania Securities Commission at **1-800-600-0007.**

Your Guide to Viatical Settlements
June 2002

A consumer service initiative of the
Pennsylvania Insurance Department
1-877-881-6388
www.insurance.state.pa.us