AQUARIUS LIFE
SOLUTIONS

Transaction Process Checklist

Welcome members of AMVETS. Below is a checklist for our life settlements closing process. Please include the following documents:

Phase I – Required Documents to Begin Quote Process

1.) Life Settlement Application Form
2.) Authorization for Release of Medical Information
3.) Authorization for Release of Personal Information
4.) Copy of medical records
5.) Current life insurance illustrations for each policy being submitted
6.) A copy of the driver's license or government issued photo identification card for the selling policy owner (if an individual) and each insured person
7.) Copy of life expectancy (LE) review (may be required by provider)

Please note that the first three items above are attached to this document.

Phase II – Required Documents to Receive Binding Offer

8.) A copy of the social security identification card or tax identification number for the selling policy owner
9.) A copy of the social security identification card for each insured person
10.) Summary of last premium payment (may be required by provider)
11.) If policy owned by trust, or group, a copy of any legal documents

Phase III – Required Documents to Close Transaction and Receive Payment

12.) A complete copy of each life insurance policy or group certificate along with related benefits information booklet for each policy being submitted
13.) Copy of policy
14.) Summary of compensation for transaction
15.) Confirmation of policyowner(s), beneficiaries, and insured(s)
16.) Letter of competency (of owner or insured), if required
17.) Any additional documents, if applicable, such as divorce decrees & bankruptcy discharge

*Please note this is our standard closing checklist. All transactions are unique and may require additional documentation as requested by the provider/purchaser.

Upon completion of the required information, please mail it to the following address:

Aquarius Life Solutions
110 Betsy Brown Road
Port Chester, NY 10573

If you have any questions regarding the closing, please call Aquarius Life Solutions at: 914-933-0063 or 914-925-0222 or email us at cashforamvets@aquariuslife.com. For additional information, please see website www.aquariuslife.com/amvets.

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Life Settlement Application for AMVETS Members

Please complete the following application in its entirety and return to Aquarius Life Solutions. The information provided by you will be used to value your life insurance policy. **This form should be completed jointly by the policy owner(s) and the policy insured(s).**

1. Primary Insured Information

Name:____ Social Security #:_____________

Current Address: ____ Date of Birth: _____ __________

City: ___________________________ State: __________ Zip Code:___________________________

Telephone: Daytime (   ) ____ _______ Evening (   ) ____ _______ Email: _____________________

Marital Status:______ Sex: ☐ Male ☐ Female Smoker? ☐ Yes ☐ No

AMVETS Affiliation:

☐ AMVETS ☐ Ladies Auxiliary ☐ Sons of AMVETS ☐ Relative of AMVETS ☐ Other

Medical History

Please provide a brief description of your medical history:

____

Name of Primary Physician:

Name of Physician: ____

Practice or Hospital name: ____

Address: _____________________________________ Telephone: (   ) ______________________

City: _______________________ State:_________ Zip:_____________ Date last seen _____________

Other Physicians:

Name of Physician: ____

Practice or Hospital name: ____

Address: _____________________________________ Telephone: (   ) ______________________

City: _______________________ State: ________ Zip: ____________ Date last seen ____________

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If you have received treatment from any other physicians, please attach an additional page including their full name, address, and telephone, as well as the nature of the treatment received.

2. Second Insured Information (if applicable)

Name:____ Social Security #:_____________

Current Address: ______________________________________ Date of Birth: _______________

City: _________________________ State: _________ Zip Code:________________________

Telephone: Daytime ( ) ____-______ Evening ( ) ____-______ Email: ____________________

Marital Status:______ Sex: ☐ Male ☐ Female Smoker? ☐ Yes ☐ No

Medical History

Please provide a brief description of your medical history:

____

Name of Primary Physician:

Name of Physician: ____

Practice or Hospital name: ____

Address: __________________________________ Telephone: ( ) ____________________

City: _____________________ State:_________ Zip:____________ Date last seen ____________

Other Physicians:

Name of Physician: ____

Practice or Hospital name: ____

Address: __________________________________ Telephone: ( ) ____________________

City: _____________________ State: ________ Zip: ___________ Date last seen ____________

If you have received treatment from any other physicians, please attach an additional page including their full name, address, and telephone, as well as the nature of the treatment received.

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3. Life Insurance Policy Information

(Please enclose a <u>copy of the policy</u> and complete the following)

<u>Policy #1</u>

Name of Insurance Company:____

Policy Number: _____________________________ Coverage/Face Amount: $_____________________

Current Account Value: $____________________ Current Cash Surrender Value: $ ______________

Annual Premium: $________________ Assignments, loans or liens: $ ___________________________

Type of Policy: ☐ Term ☐ Whole Life ☐ Universal Life ☐ Other___________________________

Issue Date: ____________ Policy classification per declaration page: ______________________________

Name of Policyowner:____ SS/Tax ID #:_______________

Current Address:____ Date of Birth: ______________

City: ____________________________ State: __________ Zip Code:___________________________

Telephone Number(s): Daytime ( ) ______________ Evening ( ) __________________________

Has the ownership of the policy changed since its original issue? ☐ Yes ☐ No

If Yes, please provide details:

____

____

Reason for selling policy:

____

____

Is the coverage being replaced? ☐ Yes ☐ No

If yes, have the applicable replacement forms been completed? ☐ Yes ☐ No

Has the policy lapsed and been reinstated within the past two years? ☐ Yes ☐ No

<u>Policy #2</u>

Name of Insurance Company:____

Policy Number: _____________________________ Coverage/Face Amount: $_____________________

Current Account Value: $____________________ Current Cash Surrender Value: $ ______________

Annual Premium: $________________ Assignments, loans or liens?____________________________

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AMVETS

Type of Policy: ☐ Term ☐ Whole Life ☐ Universal Life ☐ Other___________________________

Issue Date: _____________ Policy classification per declaration page: _______________________________

Name of Policyowner: ____ SS/Tax ID #: _______________

Current Address:____ Date of Birth: _______________

City: ______________________________ State: ___________ Zip Code:_____________________________

Telephone Number(s): Daytime (   ) _______________ Evening (   ) ___________________________

Has the ownership of the policy changed since its original issue? ☐ Yes ☐ No

If Yes, please provide details:

____

Reason for selling policy:

____

Is the coverage being replaced? ☐ Yes ☐ No

If yes, have the applicable replacement forms been completed? ☐ Yes ☐ No

Has the policy lapsed and been reinstated within the past two years? ☐ Yes ☐ No

If you have additional policies for consideration, please copy this page and complete for each policy.

How did you learn about Aquarius Life Solutions? ____

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

______________________	______________________	______________________
Signature of Policy Owner	Printed Name	Date
Signature of Primary Insured	Printed Name	Date
Signature of Second Insured	Printed Name	Date
Signature of Producer	Printed Name	Date

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Exclusive Agency Agreement/Broker Of Record

I hereby authorize and appoint Aquarius Life Solutions and any of its successors and assigns and affiliate entities as the exclusive agent of record for the policy(s) listed below for the purpose of negotiating the sale of the policy(s) as a life settlement and the undersigned agrees not to appoint any other individual or entity as a broker of record with respect to the policy(s) without first revoking this agent of record agreement by written notice to Aquarius Life Solutions.

All agent of record agreements signed by me prior to the date of this agreement are null and void. I agree that a photographic copy or facsimile of this Authorization shall be as valid as the original. I understand and agree that the Company may assign or transfer its rights hereunder without my consent.

______________________________ (Signature of Insured)	______________________________ (Signature of Policyowner) *(if other than the Insured)*
____________________/__________ (Printed Name)/ (Date)	____________________/__________ (Printed Name)/ (Date)
______________________________ (Signature of Witness)	______________________________ (Signature of Witness)
______________________________ (Printed Name)	______________________________ (Printed Name)
______________________________ (Policy Number)	______________________________ (Policy Number)
______________________________ (Insurance Company Name)	______________________________ (Insurance Company Name)

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician, medical or health care practitioner, hospice, hospital, clinic or other medical, health care or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Aquarius Life Solutions (the "Company") and/or its authorized representatives, partners or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including without limitation psychiatric conditions, or drug or alcohol abuse, of or relating to me (the "Insured").

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession or control.

I understand that the information pursuant to this Authorization will be used by the Company and its Life Settlement partners to determine my eligibility for a Life Settlement Agreement with the Company. I understand that this Authorization may be revoked by me at any time before I have accepted the purchase price from the Company or its partners. The Company will not release any information obtained to any person or organization except as may be otherwise lawfully required, as specified in the Life Settlement Agreement, or as I may further authorize. I understand and agree that the Company may disclose my medical information to financing entities and their agents, including prospective purchasers of my life insurance policy or entities that may provide the funds for its purchase. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I understand that I am entitled to a copy of this Authorization.

I agree that this Authorization shall remain valid for two years after the date on which I have signed this Authorization. I understand that the Company may request that I renew this Authorization or request a new Authorization at the end of this two-year period. I understand and agree that the Company may assign or transfer its rights hereunder without my consent.

________________________________	________________________________
(Signature of Insured)	(Signature of Policyowner) *(if other than the Insured)*
____________________/__________	____________________/__________
(Printed Name)/ (Date)	(Printed Name)/ (Date)
________________________________	________________________________
(Signature of Witness)	(Signature of Witness)
________________________________	________________________________
(Printed Name)	(Printed Name)

AQUARIUS LIFE
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AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I hereby authorize Aquarius Life Solutions (the "Company") and its Life Settlement partners to obtain my nonpublic personal financial information, including, but not limited to: a consumer report from a credit reporting agency and/or my credit payment history; and information of a financial nature that was provided on an application for my life insurance policy, including loans under my life insurance policy.

This authorization allows for the disclosure, inspection and copying of any and all records, reports and/or documents, including without limitation any underlying data, concerning my personal financial condition, including my insurance information.

I understand that the information pursuant to this Authorization will be used by the Company and its partners to determine my eligibility for a Life Settlement Agreement. The Company will not release any information obtained to any person or organization except as may be otherwise lawfully required, as specified in the Life Settlement Agreement, or as I may further authorize.

I understand that the information authorized for release may also include insurance policy information, including but not limited to forms, riders and amendments concerning the policy, as well as in-force policy value reports or illustrations.

I agree that a photographic copy or facsimile of this Authorization shall be as valid as the original.

I understand and agree that the Company may assign or transfer its rights hereunder without my consent.

______________________________ (Signature of Insured)	______________________________ (Signature of Policyowner) *(if other than the Insured)*
____________________/__________ (Printed Name)/ (Date)	____________________/__________ (Printed Name)/ (Date)
______________________________ (Signature of Witness)	______________________________ (Signature of Witness)
______________________________ (Printed Name)	______________________________ (Printed Name)