Confidential Personal Data and Life Insurance Information

Life Settlement Evaluation Authorization

After receiving the following seven pages of information, **Rumson Capital L.P.** will be able to evaluate the opportunity to present you with the current market value of your life insurance policy(s). **Include with this application/authorization the following: a) current inforce illustrations; and b) current APS's (Attending Physician Statements).**

Medical, financial, or other personal information that you provide will not be disclosed to any other person or entity without your specific written consent.

1. Personal Data

Name of Insured: ______________________________ Social Security # __________________________

Current Address: ____

City: ______________________________ State: _________ Zip Code: ___________________________

Telephone (Daytime): _______________ Telephone (Evening): _______________________________

Date of Birth: ______________ Marital Status: ____________ Sex: __Male __Female

Second (2nd) Insured: ___________________________ Social Security # _________________________

Current Address: ____

City: ______________________________ State: _________ Zip Code: ___________________________

Telephone (Daytime): _______________ Telephone (Evening): _______________________________

Date of Birth: ______________ Marital Status: ____________ Sex: __Male __Female

If policy owner is different than the above insured:

Name of Policy Owner: ____

Tax ID/Social Security # ____

Current Address: ____

City: ______________________________ State: _________ Zip Code: __________________________

Telephone (Daytime): _______________ Telephone (Evening): ______________________________

Rumson Capital, L.P., 261 Old York Rd, Ste. 711, Jenkintown, PA 19046 866-885-8433

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2. Life Insurance Policy(s) Information (if more than two, attach extra sheet)

a) Name of Insurance Company: ___________________ Policy Number ____________________

Issue date: ____________ Coverage/Face Amount: $ ___________________________________

Amount of Premium: $____________ How frequently is Premium paid _____________________

Current Cash Surrender Value: $_____________

Type of Policy (check): ___Term ___Whole Life ___Universal Life ___Other

b) Name of Insurance Company: ___________________ Policy Number ___________________

Issue Date: ____________ Coverage/Face Amount: $ _________________________________

Amount of Premium: $____________ How frequently is Premium paid __________________

Current Cash Surrender Value: $_____________

Type of Policy (check): ___Term ___Whole Life ___Universal Life ___Other

3. Medical History

Please give a brief description of your medical condition (please attach additional information if necessary):
____

Name of Physician seen for this medical condition: _______________________________________
Address: ____
City: ____________________________ State: _________ Zip Code: __________________
Telephone: _______________________
Primary or Family Physician's Name: ____
Address: ____
City: ____________________________ State: _________ Zip Code: ___________________
Telephone: _______________________

Tips about Illustrations

Term Insurance

- Provide a conversion proposal for a universal life policy, showing the policy running to maturity. Preferably, not a variable UL, as the expense charges for a variable UL are typically higher.
- If term policy is convertible only to a whole life policy, then show the dividend option reducing the premiums, then excess to paid-up additions.

Universal Life Insurance

- Provide an inforce illustration to maturity.
- Additionally, it is helpful to attach an inforce illustration showing zero future premiums if there is a positive surrender value.

Whole Life Insurance

- Provide an inforce illustration, showing future dividends reducing the premium, with excess to paid-up additions.
- For non-participating policies (Stock Companies), there are no dividends, so just run the inforce illustration to maturity.
- It is rare that showing a surrender of dividends will be advantageous, because if there are accumulated dividends they are probably supporting paid up additions.

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

rumson capital LP

RUMSON CAPITAL L.P.

This application, authorizations, notice of disclosures, current illustrations, and current APS should be mailed/faxed:

Rumson Capital L.P.
261 Old York Road Suite 711
Jenkintown, PA 19046
Telephone: (215) 886-8433
Fax: (215) 886-5300

Authorization For Disclosure Of Protected Health Information

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

- **Classes of Person Authorized to Disclose My Protected Health Information:** I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition to be released (including records protected under federal law, 42 CFR Part 2). Such records include, but are not limited to: (1) mental and physical health, (2) alcohol/drug abuse, (3) HIV, (4) STD, and (5) all lab results. I authorize each Authorized HCP to rely upon a photo static or facsimile copy or other reproduction of this authorization.
- **Classes of Person Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my PHI under this authorization to RUMSON CAPITAL L.P., M & M FINANCIAL SERVICES and their affiliates and any of their directors, officers, employees, agents, independent contractors, service providers, or other representatives (each, an Authorized Recipient).
- **Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure:** This authorization shall apply to any and all of my health and medical data, information and records, 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 the Authorized Recipient (1) to analyze, assess, evaluate, or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life if insured to the Authorized Recipient and (2) to monitor, track, or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that RUMSON CAPITAL, LP. shall broker to authorized funding institutions.
- **Expiration of Authorization:** This authorization shall expire and become void for all purposes two years from the date this authorization is executed.
- **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
- **Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization.** No HCP or other covered entity may condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

I understand that 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 Privacy Regulations"). I further understand that, 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 my no longer be protected by the HIPAA Privacy Regulations. 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.

____

Signature of Individual	Signature of Personal Representative of Individual Description of Personal Representative's Authority:

____

Print or Type Name of Individual	(Power of Attorney, Guardian at I tem or similar status)

____

Date Signed	Date Signed

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NOTICE OF DISCLOSURES*

SELLING YOUR LIFE INSURANCE POLICY IS AN IMPORTANT DECISION. PLEASE CONSIDER THE FOLLOWING WHEN ENTERING INTO THIS TRANSACTION

1. That there are possible alternatives to viatical settlement contracts for persons who have a catastrophic or life-threatening illness, including, but not limited to, accelerated benefits offered by the issuer of a life insurance policy. (FL required disclosure § 626.9923, Florida Statutes*)

2. That proceeds of the viatical settlement could be taxable, and assistance should be sought from a personal tax advisor. (FL required disclosure § 626.9923, Florida Statutes*)

3. That viatical settlement proceeds could be subject to the claims of creditors. (FL required disclosure § 626.9923 , Florida Statutes*)

4. That receipt of viatical settlement proceeds could adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate agencies. (FL required disclosure §626.9923, Florida Statutes*)

5. That all viatical settlement contracts entered into in this state must contain an unconditional rescission provision which allows the viator to rescind the contract within 15 days after the viator receives the

viatical settlement proceeds, conditioned on the return of such proceeds. (FL required disclosure § 626.9923, Florida Statutes*) Applicable in all regulated states.

6. If the insured dies during the rescission period the settlement contract shall be deemed to have been rescinded, subject to repayment of all viatical settlement proceeds and any premiums, loans and loan interest to the viatical settlement provider or viatical settlement purchaser. (Connecticut required disclosure)

7. The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the viator may inspect or receive copies of the relevant escrow or trust agreements or documents. (FL required disclosure § 626.9923, Florida Statutes*). You will be provided the name and telephone number upon request.

8. Funds will be sent to the viator within two business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that the ownership of the viatical policy or interest in the certificate has been transferred and the beneficiary designated.

9. Compensation may be paid to the Broker's who helped effect this transaction. The net amount of the compensation equals the lesser of a percent of the face amount of the Life Insurance Policy or a percent of the clients' net settlement but not to exceed 8 percent of the face amount of the life insurance policy.(FL required disclosure § 626.99181, Florida Statutes*)

10. The Viatical Settlement Provider may assign or otherwise transfer its interests in the viaticated policy to a third party.

11. That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights, a waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial advisor.

____

Signature of Viator/Applicant Date

____

Signature of Policy Owner Date

*Disclosures are applicable for all transactions and are required in certain states.

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Fax: (215) 481-9990

Authorization to Release Insurance Information

I hereby authorize my insurance company to furnish RUMSON CAPITAL L.P., or its authorized representatives, life settlement providers, or brokers, any information and forms they may request in connection to my policy (including any conversions thereof or replacements therefore). I agree that a photo static copy or facsimile of this Authorization shall remain valid for four years, absent any provision of any applicable state statute or regulation to the contrary, in which event this authorization shall remain valid for the maximum period permitted there under. I understand that all information will be kept strictly confidential.

NAME OF INSURED	SIGNATURE OF INSURED	DATE
NAME OF SECOND INSURED	SIGNATURE OF SECOND INSURED	DATE
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE
NAME OF OWNER (IF OTHER THAN INSURED)	SIGNATURE OF OWNER (IF OTHER THAN INSURED)	DATE
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE