

# The Life Settlement Alliance, Inc.

## Settlement Application

### A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)

Insured(s) \_\_\_\_\_

Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_ Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: Single/Never Married \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

If divorced please attach copies of property settlement & divorce judgment.

Are you a defendant in any suits or legal actions? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you been declared bankrupt? Yes \_\_\_\_\_ No \_\_\_\_\_

### B. LIFE INSURANCE INFORMATION (Please include a full copy of the policy)

Insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

Policy type: UL \_\_\_\_\_ VUL \_\_\_\_\_ Whole \_\_\_\_\_ Term \_\_\_\_\_ Joint \_\_\_\_\_

Policy owner, if not insured \_\_\_\_\_ State \_\_\_\_\_

Date of issue \_\_\_\_\_ Policy face amount \_\_\_\_\_

Was this policy converted? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Conversion date \_\_\_\_\_ Type \_\_\_\_\_

Please list the primary beneficiaries \_\_\_\_\_

### C. MEDICAL INFORMATION

Brief Medical History \_\_\_\_\_

Please provide the name and phone number of your physician and/or hospital that we may contact to obtain your medical records. For additional health care providers, please provide an addition sheet.

#### PHYSICIAN/HOSPITAL

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**For Agent Use:** Please include the following with the application/authorization: 1) **Current Inforce Illustration to maturity (with level death benefit and minimum premiums if a UL).** 2) Current APS (if not within the last 90 days, please provide physician information in Section C. 3) Copy of Drivers license and SS#

