



AMERICAN BROKERAGE SERVICES, INC.

Toll Free: 1-888-227-3131
Phone: 215-233-9410
Fax: 215-233-9409

803 E. Willow Grove Ave
Wyndmoor, PA 19038

INSURED'S PERSONAL INFORMATION

INSURED NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
CURRENT HOME ADDRESS			
CITY	STATE	ZIP CODE	
TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
MARITAL STATUS (PLEASE CHECK ONE)			
INSURED'S DRIVERS LICENSE # & STATE	MALE / FEMALE	PLACE OF BIRTH	

INSURED'S MEDICAL INFORMATION

NAME OF PRIMARY ATTENDING PHYSICIAN	DATE LAST SEEN	TELEPHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #1		
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #2		
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		
ADDITIONAL MEDICAL HISTORY		
ADDITIONAL MEDICAL HISTORY		

If you have any additional physicians or medical information to inform us about, please attach a separate sheet with complete details.

***In order to process and obtain accurate tentative offers, please provide your client's medical records for the past 5 years.**



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LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY	POLICY NUMBER	ISSUE DATE
<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Joint Survivorship	<input type="checkbox"/> Other
TYPE OF POLICY (PLEASE CHECK ONE)		

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

<input type="checkbox"/> Term	<input type="checkbox"/> Whole Life	<input type="checkbox"/> UL	<input type="checkbox"/> Group	<input type="checkbox"/> Other
CLASSIFICATION OF POLICY (PLEASE CHECK ONE)				

FACE AMOUNT	TOTAL POLICY LOAN AMOUNT	CASH SURRENDER VALUE
<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly
POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX)		\$ _____ PREMIUM AMOUNT

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

ADDITIONAL BENEFICIARIES

WHAT IS THE SPECIFIC PURPOSE FOR THE SALE OF THE POLICY OR POLICIES?

POLICY OWNER INFORMATION

NAME OF POLICY OWNER

SOCIAL SECURITY OR TAX ID NUMBER

NAME OF PRESIDENT / TRUSTEE (IF CORPORATE / TRUST OWNED POLICY)

DATE OF INCORPORATION / TRUST

HAS POLICY OWNER EVER DECLARED BANKRUPTCY?

IF SO, HAS IT BEEN DISCHARGED?

WHEN?

ADDRESS

TELEPHONE NUMBER

CITY

STATE

ZIP CODE



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FINANCIAL PROFESSIONAL INFORMATION

NAME OF REFERRING FINANCIAL PROFESSIONAL

TELEPHONE NUMBER

IF A FINANCIAL PROFESSIONAL DID NOT REFER YOU, HOW DID YOU FIND OUT ABOUT OUR COMPANY?

PERSONAL ACKNOWLEDGEMENTS

I do represent and warrant that the information contained in this application is correct and accurate and you may rely thereon and that I will immediately notify American Brokerage Services, Inc. (ABS) of any changes in the information. I further give my consent to ABS and its agents to release this application and all information gathered while processing including, but not limited to all medical records, notes, and lab reports, pertaining to my illness for the purpose of soliciting the sale of my life insurance policy. I acknowledge that I am submitting this application for you to evaluate the purchase of my life insurance policy and that you are under no obligation to purchase my policy.

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

Signature of Patient / Insured

Printed Name

Date

Signature of Policy Owner (*if not Insured*)

Printed Name

Date

NOTICE OF DISCLOSURE

1. There may be alternatives to a viatical or senior settlement contract including, but not limited to, accelerated benefits offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance policy.
2. Some or all of the proceeds of your settlement may be taxable. ABS strongly urges you to consult your own attorney or tax advisor concerning this transaction. ABS makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
4. Along with this application and its disclosures, ABS has provided an additional informational/disclosure booklet for the Policy Owner. If you have not received this booklet, please call 1-888-227-3131 to have one delivered to you, otherwise you acknowledge receipt of this booklet.

This disclosure is being made to you in compliance with the State Insurance Codes, where applicable.

[SIGNATURES APPEAR ON NEXT PAGE]



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I, the applicant, do hereby acknowledge that I have read and understand the contents of this disclosure.

Please Sign Before A Witness

Signature of Policy Owner

Printed Name

Date

Signature of Witness

Printed Name

Date



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Authorization for the Release of Information – HIPAA Compliant

I, _____ DOB _____ SS# _____ (*"Patient" or "Insured"*), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, "Authorized Discloser", hereafter referred to as, "AD"), to provide to American Brokerage Services, Inc. and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers including medical review services, LLC (collectively, "ABS"), any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV and/or AIDS, or drug or alcohol abuse, of or relating to 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 and control.

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by ABS about my coverage.

I understand that the ABS will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. ABS will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, ABS will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires ABS to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD. Any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

I specifically authorize and request my insurance company and each AD to rely upon a photographic copy or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. I have a full understanding of the Authorization's contents and I will retain a completed copy for future reference. I agree that this Authorization shall remain valid until and will expire on the date of my death or until the case is declined, 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 by such law.

[SIGNATURES APPEAR ON NEXT PAGE]



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Authorization for the Release of Information – HIPAA Compliant

Signature Page

Signature of Patient / Insured

Printed Name

Date: _____

Signature of Witness

Printed Name

Date: _____

Signature of Policy Owner (*if not Insured*)

Printed Name

Date: _____