



Susan J. Bruno, CPA/PFS, CFP®
 Principal
 112 Rowayton Avenue
 Rowayton, Connecticut 06853-1400
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 sbruno@beacon-wealth.com

Personal Data

Insured's Name	Date of Birth	Sex: Male Female	Social Security Number
2 nd Insured's Name	Date of Birth	Sex: Male Female	Social Security Number
Insured's Address		Phone Number	
City	State	Zip	

Is Client Applying For New Insurance? Yes No
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Life Insurance Policy Information – Policy # 1

Insurance Company	Policy Number	Issue Date
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$
Current Cash Surrender Value \$	Policy Type: Universal Life Whole Life Variable Life Term Survivorship	
Policy Owner	Owner's Social Security Number or Tax ID	
Owner's Permanent Address		
City	State	Zip
Beneficiary	Has the policy Owner ever declared bankruptcy? Yes No	

Life Insurance Policy Information – Policy # 2

Insurance Company	Policy Number	Issue Date
Face Amount \$	Total Policy Loan \$	Current Annual Premium \$
Current Cash Surrender Value \$	Policy Type: Universal Life Whole Life Variable Life Term Survivorship	
Policy Owner	Owner's Social Security Number or Tax ID	
Owner's Permanent Address		
City	State	Zip
Beneficiary	Has the policy Owner ever declared bankruptcy? Yes No	



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Insured Medical Information

Insured Medical History and Conditions		
Primary Physician		Date and Reason Last Seen
Address		Telephone
City	State	Zip
Insured's Specialist		Date and Reason Last Seen
Address		Telephone
City	State	Zip

2nd Insured Medical Information

2 nd Insured Medical History and Conditions		
Primary Physician		Date and Reason Last Seen
Address		Telephone
City	State	Zip
2 nd Insured's Specialist		Date and Reason Last Seen
Address		Telephone
City	State	Zip

Fraud Warning:

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



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Authorization for Release of Life Insurance Policy Information

I hereby authorize _____ (life insurance company) to furnish Beacon Wealth Consulting, LLC and/or The Ashar Group, its authorized representatives and/or its designee with any and all information and forms in connection with my life insurance policy number _____ (including any conversions thereof or replacements thereof).

I agree that a photographic copy or facsimile of this authorization shall remain valid for the lifetime of the undersigned 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.

I authorize Beacon Wealth Consulting, LLC and/or The Ashar Group to share this information with viatical settlement providers, viatical settlement brokers, and other parties as required. The purpose of sharing this information is to obtain quotes for viatical settlements.

 NAME OF INSURED SIGNATURE OF INSURED

 DATE OF BIRTH SOCIAL SECURITY NUMBER

 NAME OF WITNESS SIGNATURE OF WITNESS

 NAME OF POLICY OWNER (IF OTHER THAN INSURED) SIGNATURE OF POLICY OWNER

 NAME OF WITNESS SIGNATURE OF WITNESS

 SIGNED AT: CITY STATE DATE

VIATOR'S INITIALS _____



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Authorization for Disclosure of Protected Health Information

The undersigned insured(s) (hereafter referred to as “I”, “me” or “my”), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“PHI”) as follows:

1. Classes of Persons 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. I 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 Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Beacon Wealth Consulting, LLC and/or The Ashar Group, to any viatical settlement company designated by Beacon Wealth Consulting, LLC and/or The Ashar Group including, but not limited to: any medical underwriting services designated by Beacon Wealth Consulting, LLC and/or The Ashar Group and any of the protected health information retrieval services designated by Beacon Wealth Consulting, LLC and/or The Ashar Group. I understand that my PHI may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website.

3. 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 the 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 is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and



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condition in connection with any life insurance policy under which my life is insured that any other viatical settlement provider, or their affiliates, subsidiaries, or corporate parents purchases.

4. Expiration of Authorization: This authorization shall remain valid until one (1) year after the date of my death.

5. 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 such 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.

6. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I 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 redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may 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.

NAME OF INSURED

SIGNATURE OF INSURED

NAME OF WITNESS

SIGNATURE OF WITNESS



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NAME OF SECOND INSURED

SIGNATURE OF SECOND INSURED

NAME OF WITNESS

SIGNATURE OF WITNESS

SIGNED AT: CITY

STATE

DATE

VIATOR'S
INITIALS _____