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Authorization for Release of Life Insurance Policy Information

I hereby authorize _____ (life insurance company) to furnish Beacon Wealth Consulting, LLC, 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 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 _____

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, to any viatical settlement company designated by Beacon Wealth Consulting, LLC including, but not limited to: any medical underwriting services designated by Beacon Wealth Consulting, LLC and any of the protected health information retrieval services designated by Beacon Wealth Consulting, LLC. 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 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.

