COVENTRY FIRST
REDEFINING INSURANCE®

LIFE SETTLEMENT QUESTIONNAIRE

SECTION 1 LIFE INSURANCE POLICY INFORMATION

1. Insurance company ______ Policy number ______
2. Face amount ______ Issue date ______ MM/DD/YYYY
3. Type of policy ☐ term ☐ universal ☐ whole ☐ survivorship universal ☐ survivorship whole ☐ variable universal ☐ group ☐ other
4. Premium mode ☐ annual ☐ semi-annual ☐ quarterly ☐ monthly
5. Are premiums paid by automatic bank draft? ☐YES ☐ NO Date of last payment ______ MM/DD/YYYY
6. Are there any policy loans? ☐YES ☐ NO If yes, outstanding loan balance ______
7. Was the policy issued in connection with insured's employer or business (such as employer group insurance, key-man, split dollar, buy-sell, shareholder purchase agreement or other business purpose)? .... ☐YES ☐ NO

   If yes, please explain ______
8. Are there any liens against the policy or has the policy been used as collateral for any loan or other purpose? .... ☐YES ☐ NO

   If yes, please explain ______

POLICYOWNER INFORMATION *(If there are multiple owners, please attach additional pages as necessary.)*

9. Name of policyowner ______
10. Social security or tax ID number ______
11. Address ______ City ______ State ______ ZIP ______
12. Daytime phone number (____) ______ Evening phone number (____) ______
13. Has the owner ever been party to a bankruptcy? ☐YES ☐ NO If yes, date of bankruptcy ______ MM/DD/YYYY

If policyowner is an individual, please complete the following:

14. Driver's license number ______ Date of birth ______ MM/DD/YYYY
15. Marital status ☐ single ☐ married ☐ divorced ☐ legally separated ☐ widowed
16. Has the owner ever been divorced? ☐YES ☐ NO If yes, date of divorce ______ MM/DD/YYYY
17. Is the owner a U.S. citizen? ☐YES ☐ NO If no, country of citizenship ______

    If no, is the owner a permanent resident of the U.S.? ☐YES ☐ NO If yes, for how long? ______

If trust owned, please complete the following:

18. Date of trust ______ MM/DD/YYYY Name of trustee(s) ______

If corporate owned, please complete the following:

19. Name of two corporate officers and their titles ______

    ______

SECTION 2 FIRST INSURED DETAILS

1. Name ______ Social security number ______ Driver's license number ______
2. Is the insured a U.S. citizen? ☐YES ☐ NO If no, country of citizenship ______

   If no, is the insured a permanent resident of the U.S.? ☐YES ☐ NO If yes, for how long? ______
3. Address ______ City ______ State ______ ZIP ______
4. Daytime phone number (____) ______ Evening phone number (____) ______
5. Date of birth ______ MM/DD/YYYY Place of birth ______ Sex ☐ male ☐ female
6. Name of father ______ Name of mother *(including maiden name)* ______

SECTION 2 FIRST INSURED DETAILS (continued)

Primary Care Physician

7. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________

Specialty Care Physicians

List those who have treated the insured in the last five years. *(Please attach additional page(s) as necessary.)*

8. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________
9. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________
10. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________
11. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________
12. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________

SECTION 3 SECOND INSURED DETAILS (if joint policy)

1. Name ______________ Social security number______________ Driver's license number ______________
2. Is the insured a U.S. citizen? ☐YES ☐NO If no, country of citizenship ______________________
   If no, is the insured a permanent resident of the U.S.? ☐YES ☐NO If yes, for how long? ______________
3. Address ______________________ City ______________ State ______ ZIP__________
4. Daytime phone number (_____) ______________ Evening phone number (_____)______________
5. Date of birth ______________ (MM/DD/YYYY) Place of birth______________________ Sex ☐ male ☐ female
6. Name of father ______________ Name of mother *(including maiden name)* ______________

Primary Care Physician

7. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________

Specialty Care Physicians

List those who have treated the insured in the last five years. *(Please attach additional page(s) as necessary.)*

8. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP__________
   Date of last visit ______________ (MM/DD/YYYY) Reason for last visit ______________________

SECTION 3 SECOND INSURED DETAILS (continued)

9. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP ________
   Date of last visit ____________ (MM/DD/YYYY) Reason for last visit ______________________
10. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP ________
   Date of last visit ____________ (MM/DD/YYYY) Reason for last visit ______________________
11. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP ________
   Date of last visit ____________ (MM/DD/YYYY) Reason for last visit ______________________
12. Name ______________________ Phone (______) ______________
   Address ______________________ City ______________ State______ ZIP ________
   Date of last visit ____________ (MM/DD/YYYY) Reason for last visit ______________________

SECTION 4 ADDITIONAL INSURED(S) INFORMATION

1. Does the insured(s) have any other in-force life insurance policies? ☐YES ☐ NO

   If yes, please list below:

   Insurance company ______________________ Face value ______________

   Insurance company ______________________ Face value ______________

   Insurance company ______________________ Face value ______________

2. List name(s) and age(s) of child(ren), designated heir(s) and other dependent(s) *(if none, state "none")* ______________________

SECTION 5 SIGNATURES

Each of the undersigned insured(s) and policyowner(s) hereby certifies that the information provided in this questionnaire is true and correct as of the date hereof. Each of the undersigned hereby affirms its understanding that Coventry First LLC and its affiliates will be relying on the statements and responses which are being provided by all of the undersigned in the questionnaire.

Name of first insured	Signature of first insured	Date
Name of second insured *(if joint policy)*	Signature of second insured *(if joint policy)*	Date
Name of policyowner	Signature of policyowner	Date
Name of policyowner *(if second policyowner)*	Signature of policyowner *(if second policyowner)*	Date

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AUTHORIZATION

(Please sign this authorization to release medical and policy information.)

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefits manager, hospital, clinic and/or any other healthcare provider identified below (each, an "Authorized Discloser") to provide Coventry First LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("Coventry First"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Coventry First the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Coventry First in connection with the evaluation and qualification for a life settlement or other mortality-based product. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Coventry First with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions or replacements).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser or Coventry First of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a healthcare provider, healthcare 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, any of my medical information disclosed by any Authorized Discloser to Coventry First may be redisclosed by Coventry First and 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 I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

Authorized disclosers ____

____

Name of insured	Signature of insured	Date
Date of birth	Social security number	
Name of witness	Signature of witness	Date
Name of policyowner *(if other than insured)*	Signature of policyowner *(if other than insured)*	Date
Name of witness	Signature of witness	Date

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This authorization may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.