Authorization for the Release of Information – HIPAA Compliant

I, _____ DOB _____ SS# _____ (Patient / Insured), hereby authorizes any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, identified below (as each, "Authorized Discloser", hereafter referred to as, "AD"), insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Crescent Life Settlement, LLC and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers (hereafter referred to as, "CLS"), 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 CLS about my coverage.

I understand that the CLS will keep all information disclosed hereunder confidential and will only use the information for the purpose of obtaining a life insurance settlement. Furthermore, I understand that CLS will not release any information to any person or organization except as may be otherwise lawfully required or as I may further authorize; I also understand that this transaction requires CLS to re-disclosure the information to these necessary parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws; however, CLS only works with companies that maintain the same HIPAA privacy standards. I acknowledge and understand that 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 certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below. I further certify that 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 by CLS, 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 there under.

List of Authorized Disclosers (AD) (Hospitals, Doctors, Etc.):

Signature of Patient/Insured	Printed Name	Date
Signature of Witness	Printed Name	Date
Signature of Policy Owner (*if not Insured*)	Printed Name	Date
Signature of Witness	Printed Name	Date

Authorization for Release of Health-Related Information to Crescent Life Settlements, Hancock Brokerage, LLC, and its Carriers. This authorization complies with the HIPAA Privacy Rule.

Name of proposed Insured/Patient (Print) | Date of Birth | Social Security #

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, insurance company, insurance support organization, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Crescent Life Settlements, LLC and Hancock Brokerage, LLC ("the Company") and its agents, employees, representatives and carriers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under the Authorization so that the Company may: 1) Provide information to carriers so that carriers may underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) Obtain reinsurance; 3) Administer claims and determine or fulfill responsibility for coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at **Crescent Life Settlements, LLC, 900 Veterans Memorial Blvd., Metairie, LA 70005, Attention: HIPAA Privacy Official.** Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers, I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Send HIPAA form to: Crescent Life Settlements via email to **Submit@crescentls.com** and / or Fax to (504) 837-0090.

Signature of **Proposed Insured/Patient** or Personal Representative | Date

Current Mailing Address | City | State | Zipcode

Insured's Email Address

Includes these carriers, but not limited to:

Abacus	Cincinnati Life	ILS	National Life/LSW	Protective Life
Allianz	Coventry	John Hancock	National Western	Prudential
American General / AIG	Crescent Life Settlements	Legal & General (Banner)	Nationwide	Q Capital
American National	Equitable	Lincoln Financial	North American	Sagicor
Ameritas	Genworth	Magna Life Settlements	One America	SBLI
Assurity	Global Atlantic	Maple	Pacific Life	Securian Financial (Minnesota Life)
Berkshire Settlements	Guardian	Mass Mutual	Peterson International	Symetra
Brighthouse (Met Life)	Habesham Funding	Mutual/United of Omaha	Principal	Transamerica
				Voya

Authorization to Release Policy Information and Request Inforce Illustrations

By the policy owner signature below, this authorization should be considered by the issuing insurance company sufficient to release any information to the representative / entity noted below even if the representative below is not the current agent of record. Note: any request made in writing, by fax, telephone or electronic communication should be honored by the issuing insurance company without delay. A copy of this request should be considered as valid as the original.

Insurance Company Name _____ Policy Number: _____

Name(s) of Insured: _____ Insured's DOB & last 4 of SSN: _____

Name of Policy Owner (if different from Insured) _____

Owner's Address: _____

The following Inforce Illustrations are requested:
☐ 5 year Step rated illustration using minimum premium each 5 year, level death benefit, and $100 at age 100.
☐ Current inforce illustration reflecting current performance and premium being paid.
☐ Illustration assuming no future premiums to be paid.
☐ Illustration for level premium to endow policy.
☐ Illustration paying the necessary annual premium to maturity leaving $1,000 cash value at age 100.
☐ Solve for level premium to guarantee the policy to age 100 or beyond.
☑ Additional illustrations as needed.

Request for Current Policy Information:	
☐ Accumulation value	☐ Current interest rate
☐ Additional rider(s), description & charges	☐ Current premium mode
☐ Allocation (if applicable)	☐ Issued Underwriting Class
☐ Asset allocation (for variable policies) Index	☐ Last premium paid - exact amount.
☐ Conversion Details; possible? To what product?	☐ Loan balance
☐ Cost basis	☐ Loan interest rate
☐ Crediting method	☐ Net death benefit
☐ Current annual statement	☐ Net surrender value
☐ Current beneficiary designation	☐ Policy fees, loads & charges
	☐ Policy Summary

My signature below authorizes your company to release information / forms to Crescent Life Settlement / Hancock Brokerage.

Representative Name: _____ Susan Cimini

Entity Address: CRESCENT LIFE SETTLEMENTS, 900 Veterans Memorial Blvd., Metairie, LA 70005.

Entity Phone: (504) 837-2300; **Entity Fax:** (504) 837-0090; **E-Mail: Cindy@crescentLs.com or Susie@crescentLs.com**

All information regarding the policy(ies) outlined above should be directed to Crescent Life Settlements / Hancock Brokerage, LLC. They are authorized to act on behalf of the policy owner and representative named in this authorization to procure any and all information. As policy/contract owner, I authorize you to release any information to Hancock Brokerage, LLC having the business address listed above. **Note that a faxed copy of this request for information should be considered as valid as the original**. I respectfully request that any request for information be processed within five (5) business days of receipt by the issuing insurance company. Any questions you may have should be directed to Crescent Life Settlements / Hancock Brokerage, LLC named above.

Policy Owner Signature: _____ **Date:** _____

CRESCENT Life Settlements