Crescent Life Settlements, LLC
900 Veterans Blvd.
Metairie, LA 70005

Phone: **(800) 436-0719**
Email to: Submit@crescentls.com
www.crescentlifesettlements.com

Life Settlement Pre-Qualification Form

Instructions:

1. Complete this pricing request form with the most current information available.
2. Submit an inforce maturity illustration with level premiums, a level net death benefit, and leaving approximately $100 at the end of the illustrated run.
3. Click Submit and attach the illustration or email to: Susie@crescentls.com

Submit Via E-Mail

Name of Submitting Producer / Broker	**Producer / Broker Phone**	**Producer / Broker Email**	**Insureds Name (not required)**

Reason for Sale	**Insured #1 Gender** F ☐ M ☐	**Insured #1 DOB**	**Insured #2 Gender** F ☐ M ☐	**Insured #2 DOB**	**Resident State**

Tobacco Use?	
Insured #1 Y ☐ N ☐	**Insured #2** Y ☐ N ☐

Have Life Expectancy's (LE's) been completed on the insured? Y ☐ N ☐

If Yes, give date ordered & company ordered from?

Conversion Deadline or Lapse Date	Issue Rating

Insurance Carrier	Policy Type	Face Value	Policy Issue Date	Loan Amount on Policy
		$		$

Policy #	Premiums to Maturity	Policy AV / CSV & As of Date
		$

Please check 1 Box per Insured			**INSURED'S HEALTH & LIFESTYLE DESCRIPTION**
Insured #1		**Insured #2**	Please provide the most accurate health depiction - preferably based on insured's opinion.
☐	**GOOD**	☐	• Insured lives an active and independent lifestyle, may exercise regularly, travel, work, etc. • Standard health or better.
☐	**FAIR**	☐	• Insured lives an average lifestyle primarily independent but with some minor assistance. • Likely rated at least a few tables.
☐	**POOR**	☐	• Insured lives with independence but DOES require some assistance and supervision. • Would be issued highly rated.
☐	**SERIOUS**	☐	• Insured must be monitored regularly requiring daily or full-time supervision. • Would NOT qualify for insurance whatsoever.
☐	**TERMINAL**	☐	• A terminal condition that may result in a life expectancy of 24 months or less.

PRIMARY DIAGNOSIS AND OTHER MEDICAL CONDITIONS

The medical conditions listed are A-Z. The numbers 1 & 2 represent INSURED 1 and INSURED 2. If any or both have a condition, click the check box.

1	2	Condition
☐	☐	ADL Assistance With
☐	☐	ALS; Diagnosed in?
☐	☐	Alzheimer's Disease
☐	☐	Aneurysm
☐	☐	Atrial Fibrillation
☐	☐	Cancer (5+ years in remission)
☐	☐	Cancer (current)
☐	☐	Cardiac Arrhythmia
☐	☐	Cirrhosis? Stage
☐	☐	CKD; Stage
☐	☐	Congestive Heart Failure
☐	☐	COPD; Stage
☐	☐	Coronary Artery Disease
☐	☐	Coronary By-Pass; Date
☐	☐	Dementia
☐	☐	Diabetes (type 2) - Controlled
☐	☐	Diabetes (type 2) - Poor Control
☐	☐	Emphysema; Stage
☐	☐	Heart Attack; Multiple?
☐	☐	Hepatitis C
☐	☐	Hypertension - Poor Control
☐	☐	Morbid Obesity, BMI%
☐	☐	Multiple Sclerosis
☐	☐	Organ Transplant
☐	☐	Other
☐	☐	Pacemaker; Placement in?
☐	☐	Parkinson Disease; Stage
☐	☐	Peripheral Vascular Disease
☐	☐	Sedentary
☐	☐	Severe Depression
☐	☐	Short-Term Memory Loss
☐	☐	Stroke (CVA), Multiple?
☐	☐	TIA, Multiple?
☐	☐	Valve Replacement / Repair

CRESCENT
Life Settlements
Options for better solutions

Insured Name: ______________________________

DOB: ____________________

Owner's Name: ______________________________

Please provide a brief description of your medical history

Medications

#	Name of Medication	Mg	Dosage	How long have you been using?	Purpose?	Md that prescribed this medicine?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Name of Producer / Broker ____________________________