



Bach Insurance Group
220 N. Sunset Blvd. C-11
Sherman, TX 75092
Phone: 903-813-1999
Fax: 877-670-3757

JOINT LIFE SETTLEMENT
REQUEST FOR QUOTATION (RFQ)

NOTICE: This Single Life Settlement Request For Quotation is used to generate bona fide offers from qualified life insurance policy buyers. Should you choose to proceed with a formal sale of your policy, you will be required to complete an application on an appropriate state-compliant application form. This Request For Quotation does not constitute an application to sell your policy.



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Date of RFQ: ____/____/____

Insured's Name: _____ Age: _____ Date-of-Birth: _____

REQUEST FOR QUOTATION CHECKLIST

[PAGE 1 OF 2]

IMPORTANT NOTICE - The information you provide in response to this RFQ packet will allow Settlement Clearing House (SCH) to evaluate your request to sell your life insurance policy. Please answer the questions completely and to the best of your knowledge and ability. All of the information provided by you to SCH will be held by SCH in confidence in accordance with the SCH Privacy Policy and will only be used or disclosed for purposes related to the sale or solicitation for sale of your policy. Please return this RFQ and the requested materials to **Settlement Clearing House**, 803 East Willow Grove Avenue, Wyndmoor, PA 19038.

Please include the following documents with your RFQ, if applicable, and check the box below for each item you are providing. This will allow us to process your application much more efficiently.

- COMPLETED LIFE SETTLEMENT PRE-QUALIFYING WORKSHEET**
- COMPLETED AGENT AND BROKER OF RECORD FORM**
- PHOTOCOPY OF TWO FORMS OF ID** (i.e. Driver's License, SS Card, etc.), (Insured and Policy Owner)
- PHOTOCOPY OF INSURANCE POLICY OR POLICIES**
- PHOTOCOPY OF TRUST OR CORPORATE PAPERS**
- PHOTOCOPY OF DIVORCE DECREE** (Insured and Policy Owner)
- PHOTOCOPY OF BANKRUPTCY DISCHARGE** (Insured and Policy Owner)
- PHOTOCOPY OF MEDICAL RECORDS** from all physicians you have seen within the last 3 to 4 years. This includes office notes, labs, pathology reports, etc. (Our staff will obtain these if necessary)
- NECESSARY IN-FORCE POLICY ILLUSTRATION DESIGNS**
For Universal Life Policies:
 - a. An In-force illustration showing minimum level premiums and a level death benefit, at the Current Net Interest Rate running to age 100 or higher, leaving \$100-\$1,000 in cash value at age 100. Please use any cash value and dividends earned to reduce the premiums.
 - b. A 10-Year Illustration (from today's date) with level/minimum premiums, maintaining a level death benefit, using the Current Net Interest Rate, lapsing at the beginning of the 11th year after the 10-year run. Please use any cash value or dividend to pay down premiums over the life of the run.



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If loans are present on the policy:

Please run the illustrations above showing the policy owner paying the loan total off in the first year and then maintaining a level premium and death benefit for the length of the run while zeroing out cash value at the end of each run.

For Variable Life Policies:

Policy Illustrations at 4%, 6%, and 8% Gross - three illustrations each for items a and b below:

- a. An In-force illustration showing minimum level premiums and a level death benefit, running to maturity, leaving \$100-\$1,000 in cash value at age 100.
- b. A 10-year illustration showing minimum level premiums and a level death benefit, running to 10 full years from today's date and lapsing immediately at the beginning of the 11th year, showing no premiums and no death benefit in the 11th year. Zeroing out (or near zero) cash value at the end of the run.

If loans are present on the policy:

Please run the illustrations above showing the policy owner paying the loan total off in the first year and then maintaining a level premium and death benefit for the length of the run while zeroing out cash value at maturity.

PLEASE USE THESE REQUIREMENTS AS A GUIDE FOR SUBMITTING ALL NECESSARY FORMS AND INFORMATION.

IF WE DO NOT RECEIVE COMPLETE INFORMATION AS PROVIDED ABOVE, THE PROCESSING OF THIS REQUEST FOR QUOTATION WILL BE DELAYED.



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Life Settlement Pre-Qualifying Worksheet

The following case characteristics will generally result in a successful life settlement:

- Out of the contestable period
- Insured over age 60
- Death benefit greater than \$250,000
- Annual premiums less than 10% of face
- Cash surrender value less than 30% of face
- Decline in health status since issue

**Circle the appropriate number to the right and total your response.
 The table below will give you the market potential for your case.**

<u>Age</u>	<u>Points</u>
Under age 65	0
Age 65 -69	1
Age 70-74	2
Age 75-79	3
Age 80-84	4
Age 85+	5
<u>Medical Conditions/Health Status</u>	
Generally active Senior	-2
Some medical conditions – usually controlled by medication	0
Moderate medical conditions – somewhat worse off then expected	2
Significantly impaired – cancer, severe heart conditions	6
If a medical condition manifested itself after issuance of the policy	2
<u>Policy Type</u>	
Group Insurance	1
Term or Joint/Survivor (with both insureds still living)	1
Joint Survivor (with one insured deceased)	2
Whole Life	3
Universal Life	5
<u>Cash Surrender Value</u>	
Greater than 51%	-3
31%-50%	0
21%-30%	1
10%-20%	3
Less than 10%	5
<u>Premium to Face Ratio</u>	
Greater than 10%	-3
7%-9%	1
5%-7%	2
3%-5%	3
Less than 3%	4

SCORE GUIDE	TOTAL SCORE
14 + = Excellent settlement candidate	
10 - 13 = Good settlement candidate	
6 - 9 = Fair settlement candidate	
1- 5 = Settlement offer not likely	

This form is designed to give you a general idea of the marketability of your case. It does not guarantee a settlement will be offered.



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Agent and Broker of Record Form

Insured: _____	Owner: _____
Ins. Co: _____	Policy #: _____

I, _____, (policy owner) the potential seller of policy number _____, insuring the life of _____ (Insured), and issued by _____, have agreed to consider the sale of this policy through a life settlement transaction. My agent of record for the transaction is _____

(Agent) and my Broker of Record for the potential sale of the above mentioned policy is:

Settlement Clearing House
 803 East Willow Grove Avenue
 Wyndmoor, PA 19038
 888-497-2341

 Policy Owner Signature Printed Name Date

 Address

 Signature of Witness Date

 Witness's Printed Name

Note: This agreement supersedes any Broker of Record form submitted on the above mentioned policy dated prior to the date of this letter.



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LIFE INSURANCE POLICY INFORMATION

INSURANCE COMPANY	POLICY NUMBER	ISSUE DATE
<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Other	

TYPE OF POLICY (PLEASE CHECK ONE)

IF POLICY IS A GROUP POLICY, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE CONTACT WITH THE ISSUING GROUP

<input type="checkbox"/> Term	<input type="checkbox"/> Whole Life	<input type="checkbox"/> UL	<input type="checkbox"/> VUL	<input type="checkbox"/> Group	<input type="checkbox"/> Other
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CLASSIFICATION OF POLICY (PLEASE CHECK ONE)

FACE AMOUNT	TOTAL POLICY LOAN AMOUNT	CASH SURRENDER VALUE
<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly

POLICY PREMIUM PAYMENT (PLEASE CHECK THE APPROPRIATE BOX) \$ _____
 PREMIUM AMOUNT

PLEASE PROVIDE THE NAMES AND RELATIONSHIP OF ALL BENEFICIARIES OF THE POLICY (IF IT IS A TRUST, PROVIDE NAME AND ADDRESS OF TRUSTEE)

ADDITIONAL BENEFICIARIES

WHAT IS THE SPECIFIC PURPOSE FOR THE SALE OF THE POLICY OR POLICIES?

POLICY OWNER INFORMATION

NAME OF POLICY OWNER	SOCIAL SECURITY OR TAX ID NUMBER
----------------------	----------------------------------

NAME OF PRESIDENT / TRUSTEE (IF CORPORATE / TRUST OWNED POLICY)	DATE OF INCORPORATION / TRUST
---	-------------------------------

HAS POLICY OWNER EVER DECLARED BANKRUPTCY?	IF SO, HAS IT BEEN DISCHARGED?	WHEN?
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ADDRESS	TELEPHONE NUMBER
---------	------------------

CITY	STATE	ZIP CODE
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FINANCIAL PROFESSIONAL INFORMATION

NAME OF PRODUCER	TELEPHONE#	SCH MARKETING CENTER	MARKETING CENTER CODE#
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IF A FINANCIAL PROFESSIONAL DID NOT REFER YOU, HOW DID YOU FIND OUT ABOUT OUR COMPANY?



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PERSONAL ACKNOWLEDGEMENTS

I represent and warrant that the information contained in this Request For Quotation is correct and accurate to the best of my knowledge and belief. You may rely thereon and I will immediately notify Settlement Clearing House (SCH) of any changes in the information. I further give my consent to SCH and its affiliates to release this Request For Quotation and all information gathered during processing including, but not limited to, all medical and psychiatric records, notes, tests and lab reports, pertaining to my health for the purpose of soliciting the sale of my life insurance policy. I acknowledge that I am submitting this Request For Quotation for you to evaluate the purchase of my life insurance policy and that you are under no obligation to sell or purchase my policy. Should I choose to proceed with a formal sale of my policy, I understand that I will be required to complete an application on an appropriate state-compliant application form. This Request For Quotation does not constitute an application to sell my policy.

Please note. Any person who knowingly and with the intent to defraud another presents or causes to be presented any statement forming a part of or in support of an application for insurance or viatical settlement contract containing any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, commits a fraudulent viatical settlement act and is subject to civil and criminal penalties.

Signature of Insured

Printed Name

Date

Signature of Policy Owner (*if not insured*)

Printed Name

Date



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1. There may be alternatives to a viatical or life settlement contract including, but not limited to, accelerated death benefits or policy loans offered by the issuer of the policy for which you may be eligible. The terms and conditions of such benefits may vary with each individual insurance policy.
2. Some or all of the proceeds of your settlement may be taxable. SCH strongly urges you to consult with your own attorney or tax advisor concerning this transaction. SCH makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
4. The proceeds of your settlement could be subject to the claims of creditors.
5. This request for quotation is not an application to sell your policy. We will obtain quotes from various buyers and funding sources for the purchase of your policy. If you choose to proceed with a formal sale of your policy after receiving a quotation from SCH, you will be required to complete an application with the respective buyer. This application should contain all state approved disclosures as required by the state in which you are located. For a list of state statutes see the Consumer Section of the SCH website at www.schnetwork.com.
6. The procedure for obtaining a viatical settlement is as follows: SCH will obtain quotations from potential buyers and financing sources; SCH or your agent of record will review these quotes with you; should you decide to proceed with the sale of your policy based on one of these quotes, you will be required to sign an application with the buyer and proceed to contract; the sale will go to a closing in accordance with the contract and policy transfer papers will be submitted to the insurer; upon confirmation of the transfer of the policy, net proceeds are paid directly to you by the buyer or buyer's escrow agent. Commissions are paid to the agent of record and broker of record directly by the buyer and as disclosed to you at the time of the application.
7. Certain states require signed disclosures at the time you submit an application and/or sign a life settlement contract which may include disclosure of all commissions, fees and costs of the settlement. It is SCH's policy to provide complete transparency and full disclosure of all commissions, fees and costs so that you can be certain the proceeds received are appropriate.
8. Your state's laws may provide certain rights and protections including a right to rescind the life settlement contract or requirements for prompt payment of net proceeds to you. You should inquire about and be familiar with your state's viatical settlement laws.
9. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the seller and assistance should be sought from your own attorney or tax advisor concerning such issues.
10. All medical, financial and personal information solicited or obtained by your agent or SCH, including the insured's identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement including, without limitation to the life settlement buyer, funding sources and the insurance company issuing the policy. You must consent to this disclosure and the failure to consent may effect your ability to sell the life insurance policy.



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11. After your sale of a life insurance policy, the buyer may have the continuing right to request medical, financial or personal information regarding the insured in the future. This information may be provided to the buyer of the policy, funding sources or the insurance company that issued the policy. You may be required to give consent to such disclosures and renew your authorization to share this information on a periodic basis in accordance with applicable state law. You may be contacted by the buyer, broker, agent, or their authorized representatives for the purpose of determining the insured's health status on a periodic basis, although the frequency of these contacts may be limited by state law.
12. Along with this Request For Quotation and its disclosures, SCH provides an additional informational/disclosure booklet for the Policy Owner. Please contact your agent/financial advisor to receive a copy of the NAIC consumer brochure – "Selling Your Life Insurance Policy: Understanding Life Settlements."

I, the OWNER OF THE POLICY, do hereby acknowledge that I have read and understand the contents of this disclosure.

Please Sign Before A Witness

Signature of Policy Owner

Printed Name

Date

Signature of Witness

Printed Name

Date



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Authorization for the Release of Information – HIPAA Compliant

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

I understand that the SCH will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. SCH will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, SCH will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires SCH to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. 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, electronic or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. 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 when the case is declined, 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 by such law.

[SIGNATURES APPEAR ON NEXT PAGE]



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Signature Page

Signature of Patient / Insured

Printed Name

Date: _____

Signature of Witness

Printed Name

Date: _____

Signature of Policy Owner (*if not insured*)

Printed Name

Date: _____



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Joint Survivorship Policies Only – Second Insured’s Information

SECOND INSURED’S PERSONAL INFORMATION

INSURED NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CURRENT HOME ADDRESS		
CITY	STATE	ZIP CODE
TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)	
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
MARITAL STATUS (PLEASE CHECK ONE)		
INSURED’S DRIVERS LICENSE # & STATE	MALE / FEMALE	PLACE OF BIRTH

SECOND INSURED’S MEDICAL INFORMATION

NAME OF PRIMARY ATTENDING PHYSICIAN	DATE LAST SEEN	TELEPHONE NUMBER
ADDRESS		
CITY	STATE	ZIP CODE
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #1		
NAME, ADDRESS, TELEPHONE NUMBER, AND SPECIALTY OF OTHER PHYSICIAN SEEN IN LAST 24 MONTHS #2		
HOSPITAL (S) NAME, ADDRESS, TELEPHONE NUMBER THAT HAS TREATED YOU IN THE LAST 24 MONTHS FOR YOUR ILLNESS		
PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR MEDICAL HISTORY		

If you have any additional physicians or medical information to inform us about, please attach a separate sheet with complete details.



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Please note. Any person who knowingly and with the intent to defraud another presents or causes to be presented any statement forming a part of or in support of an application for insurance or viatical settlement contract containing any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, commits a fraudulent viatical settlement act and is subject to civil and criminal penalties.

Signature of Insured

Printed Name

Date

Signature of Policy Owner (*if not insured*)

Printed Name

Date



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2. Some or all of the proceeds of your settlement may be taxable. SCH strongly urges you to consult with your own attorney or tax advisor concerning this transaction. SCH makes no representation and gives no advice concerning the possible tax consequences or treatment of the proceeds of this transaction.
3. Some or all of the proceeds of your settlement may affect your eligibility for Medicaid or other government benefits and entitlements. Advice on such effects should be obtained from the appropriate agencies.
4. The proceeds of your settlement could be subject to the claims of creditors.
5. This request for quotation is not an application to sell your policy. We will obtain quotes from various buyers and funding sources for the purchase of your policy. If you choose to proceed with a formal sale of your policy after receiving a quotation from SCH, you will be required to complete an application with the respective buyer. This application should contain all state approved disclosures as required by the state in which you are located. For a list of state statutes see the Consumer Section of the SCH website at www.schnetwork.com.
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7. Certain states require signed disclosures at the time you submit an application and/or sign a life settlement contract which may include disclosure of all commissions, fees and costs of the settlement. It is SCH's policy to provide complete transparency and full disclosure of all commissions, fees and costs so that you can be certain the proceeds received are appropriate.
8. Your state's laws may provide certain rights and protections including a right to rescind the life settlement contract or requirements for prompt payment of net proceeds to you. You should inquire about and be familiar with your state's viatical settlement laws.
9. Entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the seller and assistance should be sought from your own attorney or tax advisor concerning such issues.
10. All medical, financial and personal information solicited or obtained by your agent or SCH, including the insured's identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the life settlement including, without limitation to the life settlement buyer, funding sources and the insurance company issuing the policy. You must consent to this disclosure and the failure to consent may effect your ability to sell the life insurance policy.



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12. Along with this Request For Quotation and its disclosures, SCH provides an additional informational/disclosure booklet for the Policy Owner. Please contact your agent/financial advisor to receive a copy of the NAIC consumer brochure – "Selling Your Life Insurance Policy: Understanding Life Settlements."

I, the OWNER OF THE POLICY, do hereby acknowledge that I have read and understand the contents of this disclosure.

Please Sign Before A Witness

Signature of Policy Owner

Printed Name

Date

Signature of Witness

Printed Name

Date



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

I understand that the SCH will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. SCH will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, SCH will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires SCH to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. 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, electronic or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. 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 when the case is declined, 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 by such law.

[SIGNATURES APPEAR ON NEXT PAGE]



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Signature of Patient / Insured

Printed Name

Date: _____

Signature of Witness

Printed Name

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Signature of Policy Owner (*if not insured*)

Printed Name

Date: _____