SETTLEMENT APPLICATION

A. PERSONAL INFORMATION (PLEASE PRINT OR TYPE)

Insured's Name	Date of Birth	Social Security Number
2nd Insured's Name	Date of Birth	Social Security Number
Address		Phone Number
City	State	Zip Code

Marital Status: Married _____ Single/Never Married _____ Widowed _____ Divorced _____

B. LIFE INSURANCE INFORMATION

Insurance Company	Policy Number	Face Amount
Date of Issue	Policy Type (WL, UL, SUL, Term, etc…)	Current Premium
Policy Owner	State of Residence	Beneficiary(s)

C. MEDICAL INFORMATION

Insured Medical History _____

Primary Physician	Telephone Number
Specialist	Telephone Number

2nd Insured Medical History_____

Primary Physician	Telephone Number
Specialist	Telephone Number

Is the policy owner or insured a defendant in any suits or legal actions? Yes _____ No _____
Has the policy owner or insured ever declared bankruptcy? Yes _____ No _____

AUTHORIZATION FOR RELEASE OF POLICY INFORMATION

By executing this Authorization for Release of Policy Information (this "Authorization"), the undersigned person ("Signatory"), an owner of one or more life insurance policies or duly acting on behalf of such owner ("Policyowner", who may or may not also be Signatory), hereby authorizes the insurance carrier identified below, and its respective affiliates, assigns, and designees (collectively, "Insurer"), to release to LifeRoc Capital, LLC and its respective officers, directors, employees, agents, representatives, affiliates, assigns, and designees (collectively, "Company"), by voice, phone, facsimile, e-mail, mail, and/or other commercially-reasonable means of transmission (as the context reasonably supports), any and all information and/or documentation which Company requests in connection with Policyowner and/or the Policy, without limitation, including but not limited to financial and credit-related information of Policyowner, a true, correct & complete copy of the life insurance policy described below (the "Policy"), certificates evidencing the issuance and in-force status of the Policy, annual statements, in-force Illustrations, verifications of coverage, account values, Policy information, Insurer forms, rider or amendment details, and other Policy-specific or related information, for any and all legal purposes. Signatory may revoke this Authorization in writing if such revocation is delivered to Company via first-class certified postage-prepaid mail, return receipt requested. Any otherwise-valid revocation of this Authorization by Signatory is not effective to the extent Company and/or Insurer acts in good faith reliance on this Authorization.

Policy Information:

Insurer/Carrier:	**Policy Number:**
Owner Name:	**Owner TIN or SSN:**

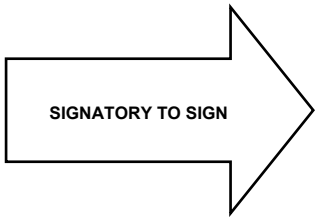
Persons Authorized to Act on Behalf of the Company:

Alyssa Durr (Case Manger), Geoff Palya (Director), Brandon Marz (CSO), Travis Gallina (Director of Operations), and all other LifeRoc Capital, LLC employees, persons, designees and representatives.

Authorization & Signature

This Authorization may be signed in any number of counterparts, if and as needed, which together shall constitute one and the same Authorization, and a photocopy or facsimile of this signed Authorization shall be treated, and may be relied upon, as an original.

By signing this Authorization, Signatory acknowledges and agrees this Authorization is written in plain English, Signatory has read and fully understands this Authorization, and Signatory will retain a copy of this Authorization, once duly completed and signed by Signatory, for his, her, or its records, respectively.



SIGNATURE OF OWNER

X: _____

Owner Name: _____

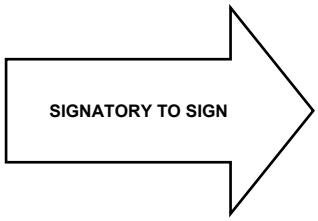
Signor Name: _____

Title: _____

Date: _____

INSURED AUTHORIZATION TO RELEASE HEALTH INFORMATION

By executing this Insured Authorization Form (this "Form"), the undersigned authorizing person, who is and/or seeks to be insured (the "Insured") under one or more life insurance policies, or who is duly authorized to act on behalf of the Insured if not the Insured, acknowledges the necessity for personal and protected health, medical, and other information, documentation, and records regarding the Insured to be released to LifeRoc Capital, LLC and its respective affiliates (assigns, and designees (collectively, "Recipients"; each, a "Recipient"), to facilitate review and/or underwriting by the Recipients of one or more proposed life insurance-related or other transactions with one or more Recipients, which relate to and/or involve the Insured, as well as for all other legal purposes, without limitation. The undersigned hereby authorizes and instructs [A] any health care provider, not limited to any type or source; [B] each insurer identified in the "Insurer List" below in this Form (each, an "Insurer"), any affiliate of any Insurer, any reinsurer of any Insurer, and any successor-in-interest of any Insurer and/or of its respective affiliates and reinsurers; [C] any insurance support organization; [D] any consumer, credit, and/or public record reporting agency or entity, including but not limited to LexisNexis, Westlaw, TransUnion, Experian, Equifax, and their respective affiliates; [E] any person authorized to represent any person or entity described by any or all of Items [A] through [D] immediately above, inclusive, for any purpose described in this Form; and [F] all other persons and entities having knowledge or records of the Insured and/or the diagnosis, treatment, and prognosis with respect to any physical and/or mental condition of the Insured (collectively, the "Authorized Parties"), to release, disclose, and provide to each Recipient, without delay or restriction: [1] any and all individually identifiable health information regarding and/or relating to the Insured, including but not limited to medical records, reports, pharmaceutical and prescription drug records, diagnostic testing, and lab results, including but not limited to such relating to diagnosis or treatment of Human Immunodeficiency Virus, sexually transmitted diseases, and suicidal or mental disorders; [2] all other information concerning the health of the Insured, without limitation; and [3] all other information regarding the Insured as allowed and/or required by applicable law, including but not limited to credit, employment, and consumer background information (items [1], [2], and [3], together, "Insured Information"). For purposes of this Authorization Form, the Insurer List (the "Insurer List") consists of the following insurers: Accordia Life, American General, Americo, Ameritas Life, Allianz, American National, Assurity, AXA Equitable, Brighthouse, Cincinnati Life, Foresters, IMS Associates, John Hancock, Lafayette Life, Legal & General, Lincoln Financial, Life of the Southwest, MassMutual, NACOLAH, Nationwide, New York Life, Pacific Life, Penn Mutual, Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life, Prudential Life Insurance Co. of America, Pruco Life Insurance Company, Sagicor Life, SBLI, Securian, Symetra Life, Transamerica, United of Omaha, and Zurich American Life. The undersigned acknowledges and agrees that this Form permits, but does not require, Recipients to seek and obtain Insured Information from any of the Authorized Parties. This Form is valid for a period of twenty-four (24) months following its date unless this Form is validly rescinded by the undersigned prior to the expiration of that time period, provided, however, any otherwise-valid revocation of this Form is not effective to the extent any person or entity acts in good faith reliance on this Form. If for any reason the undersigned desires to rescind the authorization set forth in this Form, the undersigned may do so in a signed writing clearly indicating that intent, delivered to: LifeRoc Capital, LLC, 19000 MacArthur Boulevard, Suite 450, Irvine, CA 92612, Fax: 310-819-9512. The undersigned further understands that disclosures made pursuant to this Form may be further disclosed by Recipients to third parties and no longer subject to protection by state, federal, and/or municipal laws, regulations, and rules governing privacy and confidentiality. The undersigned acknowledges that authorizing disclosure of Insured Information through this Form is voluntary, that the undersigned can refuse to sign this Form, and that the undersigned need not sign this Form in order to assure treatment, payment, enrollment or eligibility for insurance benefits by the Recipients. By signing this Form, the undersigned acknowledges and agrees that this Form is written in plain English, that the undersigned has read and fully understands this Form in its entirety, that the undersigned has received a copy of this Form to keep, and that a photocopy or facsimile of this Form, once completed, signed by the undersigned, and witnessed, is as valid as, and shall be treated as, an original of such signed Form.



SIGNATURE OF INSURED

X: _____

Insured Name: _____

Signor Name: _____

Title: _____

Date: _____