LIFEROC CAPITAL, LLC

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GENERAL POLICY INQUIRY PACKET

Submission Checklist

Please use this Checklist (this "Checklist") as a reference guide, to help you determine if you have completed and assembled items that we need in order to expedite review of your file.

To help guide you, indicate "Yes" if included, "No" if applicable but not included, and "N/A" if not applicable.

Included (Yes / No / N/A)	Items We Require for Expedited File Review
	Forms Accompanying This Checklist, Properly Completed and Signed by Each Owner & Each Insured • By each owner of the subject life insurance policy (the "Policy"): (1) Consumer Notice Form, (2) Consumer Data Form, and (3) Consumer Authorization Form • By each person the Policy insures (each, an "Insured"): (1) Insured Data Form and (2) Insured Authorization Form
	Color Copy of Policyowner Photo Identification A color copy of valid, current government-issued photo identification of each policyowner (each, a "Policyowner")
	Color Copy of Insured Photo Identification A color copy of valid, current government-issued photo identification of each Insured
	Copy of the Policy If a copy of the Policy is not immediately available, please forward a copy to us as soon as possible
	Copy of Most Recent Annual Statement and/or Bill
	Copy of Policyowner Documentation (if Trust / Corporate / Entity Owned) Copies of all applicable documentation if Policy is owned in whole or in part by a non-natural person (i.e., Trust Agreement if Policy is trust-owned, Corporate Resolution if Policy is corporate-owned, etc.)
	Copy of Power of Attorney (POA) Documentation (if applicable) Copy of any power of attorney if any signatory is an attorney-in-fact acting pursuant to such power

POLICY INFORMATION SHEET

About the Policy (the "Policy")

Carrier:	**Policy Number:**
Base Face Amount:	**Policy Issue Date:**
Insuring (check one): ☐ Individual ☐ Joint-Survivor	**Rate Class at Issue:**
Policy Type (check one): ☐ UL ☐ GUL ☐ IUL ☐ VUL ☐ Term Convertible ☐ Term Non-Convertible ☐ Whole Life ☐ Group	
Guaranteed Term Period (if Term):	**Term Conversion Expiration Date (if Term):**
List all Riders:	
Current Account Value:	**Current Cash Surrender Value:**
Outstanding Loan Balance:	**Date Last Premium Paid:**
Amount of Last Premium Paid:	**Mode (check one):** ☐ Annual ☐ Semi An. ☐ Quarterly ☐ Monthly
Reason for selling the Policy:	

Insured 1 Name | Alive?	Insured 2 Name | Alive?
Beneficiary Name(s) & Beneficiary Amount/Percentage	
Policy Address of Record	
Address:	
Natural Person Owner 1 (if applicable; if none, skip)	
Full Name:	**Ownership %**
SSN:	**DOB:**
Address:	
Landline Phone:	**Cell Phone:**
E-mail:	**Power of Attorney In Effect?: ☐ YES or ☐ NO**
Marital Status:	**Spouse Name:**
Ever been divorced? ☐ YES IN YEAR _____ **or ☐ NO**	**Ever filed bankruptcy? ☐ YES** IN YEAR _____ **or ☐ NO**
Natural Person Owner 2 (if applicable; if none, skip)	
Full Name:	**Ownership %**
SSN:	**DOB:**
Address:	
Landline Phone:	**Cell Phone:**
E-mail:	**Power of Attorney In Effect?: ☐ YES or ☐ NO**
Marital Status:	**Spouse Name:**
Ever been divorced? ☐ YES IN YEAR _____ **or ☐ NO**	**Ever filed bankruptcy? ☐ YES** IN YEAR _____ **or ☐ NO**
Natural Person Owner 3 (if applicable; if none, skip)	
Full Name:	**Ownership %**
SSN:	**DOB:**
Landline Phone:	**Cell Phone:**
E-mail:	**Power of Attorney In Effect?: ☐ YES or ☐ NO**
Marital Status:	**Spouse Name:**
Ever been divorced? ☐ YES IN YEAR _____ **or ☐ NO**	**Ever filed bankruptcy? ☐ YES** IN YEAR _____ **or ☐ NO**
Entity-Based Owners 1 (if applicable; if none, skip)	
Entity Name:	
TIN / FEIN:	**Formation Date:**
Address:	
Ever filed bankruptcy? ☐ YES IN YEAR _____ **or ☐ NO**	

Entity Signor 1	
Full Name	**Title**
E-Mail:	**Phone:**
Entity Signor 2 (if applicable or required)	
Full Name	**Title**
E-Mail:	**Phone:**
Entity Signor 3 (if applicable or required)	
Full Name	**Title**
E-Mail:	**Phone:**

Entity-Based Owner 2 (if applicable; if none, skip)	
Entity Name:	
TIN / FEIN:	**Formation Date:**
Address:	
Ever filed bankruptcy? ☐ YES IN YEAR _____ **or ☐ NO**	
Entity Signor 1	
Full Name	**Title**
E-Mail:	**Phone:**
Entity Signor 2 (if applicable; if none, skip)	
Full Name	**Title**
E-Mail:	**Phone:**
Entity Signor 3 (if applicable; if none, skip)	
Full Name	**Title**
E-Mail:	**Phone:**

Policy History Questions

At the time the Policy was issued, did each policyowner and each original beneficiary of the Policy have a valid insurable interest in the life of the insured person(s) to the extent required pursuant to then-applicable law?

(Check One):	**☐ YES or ☐ NO**	**If NO, explain below how & why not.**

_____
_____

Was the Policy ever the subject of any premium financing activity, arrangement, or agreement?

(Check One):	**☐ YES or ☐ NO**	**If YES, respond to both items immediately below.**

1. Identify by name each lender:
   _____
   _____
2. Was the Policy the subject of any non-recourse financing? (Circle One): YES or NO

Has any person or entity other than a policyowner or an insured under the Policy ever participated in the payment of any premium due with respect to the Policy?		
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**

List the name(s) of any person or entity who participated in payment of premium on the Policy and describe the reason for his/her/its/their participation in premium payments:

_____

_____

Has the Policy ever been the subject of a collateral assignment?			
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**	
Name of Assignment Holder(s)		**Describe Reason for Assignment**	**% of Death Benefit or $ Amount of Entitlement**

Is any beneficiary of the Policy the subject of a requested or actual irrevocable beneficiary designation?		
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**
Irrevocable Beneficiary Name(s)		**% of Death Benefit or $ Amount of Entitlement**

Does there exist any lien, judgment, restriction, obligation, or other encumbrance which could affect the Policy and/or any rights or benefits available thereunder?		
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**

Describe each such encumbrance:

_____

_____

Has ownership of the Policy ever changed since time of issuance?			
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**	
Name of Previous Owner(s)		**Describe Reason for Policy Transfer**	**Date of Policy Transfer**

Was the Policy issued as a result of exercise of conversion, exchange, or split policy option rights by any past or current policyowner?		
(Check One):	**☐ YES or ☐ NO**	**If YES, provide the information requested immediately below.**
Original Policy Number:		**Date of Original Policy Issuance:**

INSURED INFORMATION SHEET

About the Insured

First Name:	**Last Name:**	
Landline Phone:	**Cell Phone:**	
E-mail:	**Occupation:**	
DOB:	**SSN:**	
DL State:	**DL #:**	**Power of Attorney In Effect?: ☐ YES or ☐ NO**
Street Address:		
City:	**State:**	**Zip:**
Marital Status:	**Spouse Name (if applicable):**	
Bankruptcy filed? ☐ YES IN YEAR(S) _____ **or ☐ NO**	**Total face value of all in-force life insurance: $**	

Insured Health Profile

Height:	**Weight:**	**Ever applied for disability? ☐ YES** IN YEAR(S) _____ **or ☐ NO**
Do You Still Drive?: ☐ YES or ☐ NO		**Have you had any fall(s) in past 5 years? ☐ YES or ☐ NO**

Tobacco Use in the past 5 years (If none, write "None" to indicate that)

Check Product Type (below)			Date Last Used	Amount / Frequency
☐ Cigarettes	☐ Cigars	☐ Other		

Current Medication(s) (If none, write "None" to indicate that)

Medication Name	Reason Taking	Length / Frequency / Dosage

Major surgeries or illnesses in the past 10 years (If none, then write "None" to indicate that)

Date	Type	Reason / Cause	Current Status of Condition

Has the Insured ever been treated for or diagnosed with any of the following? *Answer with "Yes" or "No" as applicable; provide details in the "Additional Comments" section below.*		
Alcohol/Drug Abuse ☐	Arthritis ☐	Anemia/Blood Disorder ☐
Brain Disorder ☐	Breathing Problems ☐	Broken Bones ☐
Cancer ☐	Chronic Pain ☐	Dementia/ Alzheimer's ☐
Depression/Anxiety ☐	Diabetes ☐	Dizziness/Vertigo ☐
Heart Attack ☐	Heart Disease ☐	High Blood Pressure ☐
High Cholesterol ☐	Immune Disorder ☐	Kidney Issues ☐
Liver Issues ☐	Neurological Issues ☐	Osteoporosis ☐
Pancreas Issues ☐	Sleep Apnea ☐	Stomach/Digestive/Colon ☐
Stroke/TIA ☐	Tumors/Cysts ☐	Thyroid Issues ☐

Additional Comments / Other Health Issues (add additional page(s) as necessary):

Insured Doctor & Hospital Information (past 5-10 years)

Primary Physician	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**
Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City / State:**
Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**
Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**

Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**
Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**
Specialist / Facility	
Name:	**Specialty:**
Date Last Seen:	**Reason:**
Telephone:	**City & State:**

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 Manager), Kelly Krier (Case Manager), Geoff Palya (Director), Brandon Marz (CSO), Nick Williams (VP), 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: _____

Signor Title: _____

Date: _____

INSURED AUTHORIZATION TO RELEASE HEALTH INFORMATION (HIPAA Authorization)

By executing this Insured Authorization Form (this "Form"), the undersigned (the "Insured") under one or more life insurance policies (the "Insured") authorizes the disclosure of my protected health information ("PHI") as defined under the regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 as follows:

1. I authorize each doctor, hospital, nurse, pharmacy, pharmacy benefit manager, physician, physician practice group, and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below.

2. I authorize each Authorized HCP to disclose my PHI under this authorization to LifeRoc Capital, LLC and its respective affiliates, subsidiaries, independent contractors, agents, representatives, service providers; and any of their respective successors, assigns and transferees of any life insurance policy insuring my life and any life insurance producer, and if the policy was issued less than two years from the date of application for a life settlement contract, to the insurance company that issued the policy covering my life (each, an "Authorized Recipient"). I understand that my PHI may be obtained by a third-party provider and may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website.

3. This authorization shall apply to any and all of my health and medical data information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. regulations, including, without limitation: (1) any life expectancy analysis relating to me; (2) drug or alcohol abuse; (3) mental health conditions, including, but not limited to, treatment in a psychiatric hospital; (4) a sexually transmitted disease; (5) a communicable disease required to be reported to a state health agency; (6) infection with human immunodeficiency virus(HIV), test results for exposure to HIV infection, or diagnosis of having ARC (AIDS-related complex) or AIDS caused by HIV infection or another sickness or condition caused by or derived from such HIV infection, or other HIV-related information; (7) mental retardation; (8) a genetic disease, genetic information, or results from genetic tests; (9) a condition that resulted in residence and/or treatment in a sanatorium, rest home, nursing home, boarding home, or related institution; or (10) a condition for which treatment was provided by an ambulance service.

4. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (I) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy in connection with the possible sale of any life insurance policy under which my life is insured to any Authorized Recipient and (2) to monitor, track or verify my health, life or medical status and condition in connection with any life insurance policy under which my life is insured that LifeRoc Capital, LLC purchases.

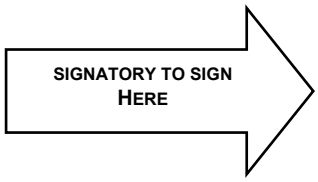
5. This authorization shall remain valid until, and shall expire on, the date that is one (1) year after the date of my death, or such other date, if any, as may be required by applicable law or regulation.

6. If at any time the undersigned desires to rescind the authorization set forth in this Form, the undersigned may do so in a signed writing indicating that intent, delivered to: LifeRoc Capital, LLC, 19000 MacArthur Boulevard, Suite 450, Irvine, CA 92612, Fax: 310-819-9512; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

7. No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

8. I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA and its regulations.

I certify that I am executing and delivering this authorization freely. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.



SIGNATURE OF INSURED

X: _____

Insured Name: _____

Signor Name: _____

Signor Title: _____

Date: _____