

MADISON BROKERAGE CORP (MBC) LIFE SETTLEMENT CHECKLIST

Please make sure to complete each section in its entirety. Missing information will delay our ability to market your case and ultimately secure a settlement offer. This application contains 7 pages in its entirety.

Items Required:

- 1. Completed Broker/Agent Data information
- 2. Completed Insurance Information section
 - A. Owner
 - B. Policy Information
 - C. First Insured
 - D. Second Insured
 - E. Beneficiary Information
- 3. Current medical records for the past 5 years
- 4. Completed and signed Authorization for Disclosure of Protected Health Information
- 5. Completed and signed Policy Release
- 6. Completed and signed Broker Authorization
- 7. Current illustration solving for level premium, level death benefit with \$1 cash surrender value at maturity. (Please attach.)
- 8. Completed and signed New York Authorization

1. BROKER/ AGENT DATA

Broker/Agent Name:		Signature:	
Agency Name:			
Address:			
City:		State:	Zip:
E-mail address:	Phone:		Fax:



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MADISON BROKERAGE CORP.

65 MADISON AVE., STE 200, PO BOX 1940
MORRISTOWN, NJ 07962-1940
973.539.3232/888.539.3232/FAX 973.539.3737



2-A. INSURANCE INFORMATION/POLICY OWNER

Name of Policy Owner(s):		
Name of Signing Officer (If Corporate Owned):		Officer Title:
Name of Trustee(s) (If Trust Owned):	Date of Trust:	Tin or SSN
Address:		
City:	State:	Zip:
E-mail address:	Phone:	Fax:
If individually owned, has policy owner ever been? (Check all that apply)		
<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Bankrupt		

2-B. INSURANCE INFORMATION/POLICY INFORMATION

Insurance Company:	Policy Number:	Issue Date:
Face Amount:	Total Policy Loan:	Cash Surrender Value:
Annual Premium Payment:	Next Premium Date:	
Last Premium Paid Date:	Amount Paid:	
Premium Mode:		
<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly		
Type of Policy:		
<input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> SUL <input type="checkbox"/> WL <input type="checkbox"/> SWL <input type="checkbox"/> VUL <input type="checkbox"/> SVUL <input type="checkbox"/> Other		
<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Converted Group		
Was this Policy Premium Financed?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, who is the Lender?	
Loan Payoff Amount:	Loan Due Date:	

Complete this page for each policy.

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2-C. INSURANCE INFORMATION/FIRST INSURED

Name:		Date of Birth:	SS#:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Height:	Weight:
Address:				
City:		State:	Zip:	

2-D. INSURANCE INFORMATION/SECOND INSURED

Name:		Date of Birth:	SS#:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Height:	Weight:
Address:				
City:		State:	Zip:	

2-E. BENEFICIARY INFORMATION/ATTACH ADDITIONAL PAGE IF NECESSARY

Name:		Date of Birth:	SS#:	
Address:				
City:		State:	Zip:	



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3. CURRENT MEDICAL RECORDS FOR THE PAST 5 YEARS

Client's Name(s): _____	Soc. Sec. #: _____
<input type="checkbox"/> * What physician(s) have you consulted in the past 5 years?	
Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____	Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____
Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____	Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____
Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____	Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ _____ Reason: _____
<input type="checkbox"/> * In what hospitals, clinics, etc. have you ever been treated?	
Physician(s) name: _____ Hospital/clinic/etc.: _____ Phone numbers: _____ Address: _____ _____ Reason: _____ Date: _____	Physician(s) name: _____ Hospital/clinic/etc.: _____ Phone numbers: _____ Address: _____ _____ Reason: _____ Date: _____
<input type="checkbox"/> * Please list all medications	
_____	_____
_____	_____



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4. AUTHORIZATION FOR DISCLOSURE OF POLICY INFORMATION AND PROTECTED HEALTH INFORMATION (HIPAA COMPLIANT)

Patient's (Insured) Name: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned, hereby authorize the disclosure of my protected health information as follows:

1. **Classes of Persons authorized to Disclose My Protected Health Information:** I authorize any physician, medical practitioner, physician practice group, hospital or medical related facility, health care provider or other institution or person(s) having any medical records, charts, X-rays, laboratory work or similar information regarding my health ("Authorized Disclosure"), to release and disclose such information ("Protected Health Information") as provided in this authorization. I authorize each Authorized Disclosure to rely upon a photographic or facsimile copy or other reproduction of the document.
2. **Persons Authorized to Receive My Protected Health Information:** I authorize my Protected Health Information to be released and disclosed by each Authorized Discloser under this authorization **Madison Brokerage Corp.** any of its principals, employees, agents or other authorized representatives and/or their successors, assigns, designees and affiliated entities (collectively, the "Authorized Recipient").
3. **Description of Protected Health Information Authorized for Disclosure and the Purpose for such Disclosure:** authorization shall apply to any and all of my health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including, but not limited to, the following:

Physician's/nurse's notes;
Examination summaries;
Reports and Orders;
Medication and Prescription Drug records;
Radiology, pathology and other laboratory or test reports; and
Other information/documentation included in a medical file.

This information and all disclosures of my Protected Health Information made pursuant to this authorization are for the purposes of allowing the Authorized Recipient (1) to evaluate or cause an evaluation to be prepared of my life expectancy based upon my health and medical status and condition in connection with the possible sale of any and all life insurance policies under which my life is insured and (2) to verify, track and monitor my health and medical status and condition in connection with any and all life insurance policies under which any life is insured that are sold.

4. **Expiration of Authorization:** This Authorization shall remain valid until and shall expire on, the date of my death.
5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Disclosure by notifying such Authorized Discloser or my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided that any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation or if this authorization was obtained.

I acknowledge and understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPPA Privacy Regulations"). I further understand that, as a result of this authorization, my Protected Health Information disclosed by any Authorized Discloser to the Authorized Recipient may be redisclosed by the Authorized Recipient and that my Protected Health Information that is disclosed to the Authorized Recipient may not longer be protected by the HIPPA Privacy Regulations.

I certify that I am executing and delivering this authorization freely, voluntarily and unilaterally as of the date written below. I further certify that I understand this authorization written in plain language and that I have retained a copy of this signed authorization for future reference.

Signature of Patient (Insured)

Date



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5. POLICY RELEASE- Complete one for each policy

AUTHORIZATION FOR RELEASE OF POLICY INFORMATION

I, _____, hereby authorize, _____
 Name of Policy Owner Name of Insurance Company

the issuer of insurance policy number(s) _____

insuring the life/lives of _____ and _____

to release any and all policy information to Madison Brokerage Corp (MBC), its successors, assigns and authorized representatives. This information may include, but is not limited to, the following information and documents:

- a. A copy of the policy, including original application and attached riders
- b. Any forms related to the Policy and the rights of the insured and/or owner, including beneficiary designations, assignments, change of ownership, premium payments, policy loans and withdrawals, payment provisions and/or conversion.
- c. Current illustrations as may be required
- d. Any other information related to my policy

A photocopy of this authorization shall be as valid as the original. This authorization shall remain valid for the life of the undersigned (or the last to survive), 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 law. I also understand that I may withdraw this consent pursuant to any applicable state statute or regulation.

 Name of Policy Owner Signature Date

 Name of Policy Owner (2) Signature Date

 Owner Address Tax ID #



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6. BROKER AUTHORIZATION

BROKER AUTHORIZATION

I/we, the undersigned Policy Owner(s) hereby authorize Madison Brokerage Corp (MBC) to act as my settlement broker for the purpose of obtaining quotes and facilitating a life and/or viatical settlement for policy number(s) _____ issued by _____ on the life/lives of _____ and _____.

The effective date of this document is the date of signature and this authorization shall be in full force and effect for 180 days from the date of signature. No other settlement broker shall be allowed to transact business on the above referenced policies until the expiration of this authorization.

SIGNATURES

_____	_____	_____
Name of Policy Owner	Signature	Date
_____	_____	_____
Name of Policy Owner (2)	Signature	Date



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8. AUTHORIZATION TO RELEASE INFORMATION-FOR USE IN NEW YORK

MADISON BROKERAGE CORPORATION

65 MADISON AVE., STE 200, PO BOX 1940
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Phone: 973.539.3232 Toll Free: 888.539.3232 FAX 973.539.3737
EMAIL: sales@madisonbrokerage.com

AUTHORIZATION TO RELEASE INFORMATION - For Use in New York

The undersigned is the owner of, or names insured under, one or more life insurance policies identified below. In order to effect a life settlement contract between the owner and a life settlement provider, or to effectuate the sale or transfer of a life settlement contract or a settled policy, or interest therein, the undersigned each hereby consent to the release of information to the authorized recipients specified herein.

Information Authorized to be Released: Any information (1) concerning or related to the identity of the owner of, or the named insured under, the life insurance policies identified below, (2) that there is a reasonable basis to believe could be used to identify the insured or owner, and (3) concerning or related to the owner's or insured's financial or medical information may be released to the authorized recipients (as defined below). Such information may include (but is not limited to): the name, address, telephone numbers, social security number, tax records, medical records, credit information and other non-public personal information of or related to the insured or the owner, or representative thereof; and the related insurance policy number(s).

Authorized Recipients of Information: Information authorized to be released hereunder may be released to (1) any life settlement broker, (2) any life settlement provider (a "life settlement provider"), (3) any person who may seek to purchase from such life settlement provider any life insurance policy insuring the below identified insured's life or other insurance product owned by the below identified owner, (4) any financing entity of a life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (5) any service provider, including, but not limited to, any life expectancy underwriter, escrow agent or post-purchase policy servicer, (6) any life insurance or annuity company that has issued a life insurance policy insuring the below identified insured's life, and (7) any of the respective affiliates, directors, officers, employees, agents, representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately forgoing clauses (1) through (6), inclusive (each, an "authorized recipient"). Each authorized recipient in receipt of information authorized to be released by this authorization may share any such information with any other authorized recipient as if such other authorized recipient had received such information directly from the undersigned.

The undersigned each certify that this authorization has been made freely, voluntarily and without coercion and that the information shown below is accurate and complete to the best of the undersigned's knowledge. The undersigned understands that any revocation of this authorization will not apply to information that has already been released in response to this authorization. Redisclosure of the undersigned's information by those receiving the above authorized information may be accomplished without the undersigned's further written authorization and may no longer be protected. The undersigned releases any authorized recipient from any and all liability for actual or alleged damages to the undersigned as a result of good faith compliance with this authorization. This authorization is valid for the duration of the life insurance policy(ies) specified below, provided that this authorization shall be of no force or further effect if a life settlement contract is not effected. The undersigned each acknowledge receipt of a copy of this authorization.

A copy of this authorization may be accepted as an original. This authorization may be sent via facsimile transmission.

LIFE INSURANCE POLICY INFORMATION

Insurance Company

Policy Number

Insurance Company

Policy Number

Insurance Company

Policy Number

Continued on next page



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New York Authorization continued

POLICY OWNER INFORMATION

 Policy Owner Name

 Signer's Printed Name

Signature, Title

Date

 Street Address

 City

State

Zip Code

 Witness Name

Witness Signature

Date

INSURED INFORMATION

 Insured Name

Insured Signature

Date

 Street Address

 City

State

Zip Code

 Witness Name

Witness Signature

Date



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