Long-Term Care Benefit Plan | Release Form

LIFE INSURANCE INFORMATION RELEASE FORM

Life Insurance Policy Number

Issued by

Is owned by

Insured the life of

I authorize the release to America's 1st Financial and/or Life Care Funding, LLC or its designee, any or all information concerning the above policy.

Policy Owner Signature

Date

Type or Print Name

Policy Owner SSN#

Long-Term Care Benefit Plan | Authorization

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, authorize disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

1. Classes or Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, 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 authorize each Authorized HCP to rely upon a photo-static or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to America's 1st Financial and/or Life Care Funding, LLC, and any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure and Purpose of Disclosure: 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. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) 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, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore.

4. Expiration: this authorization shall remain valid until, and shall expire, one year after the date of my death.

5. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me bu such Authorized HCP; 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.

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Health Plan Benefits on Provisions of this Authorization. No Authorized HCP or other covered entity may condition treatment, payment, enrollment or eligibility for health plan benefits on whether this authorization is signed or not.

I 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 (HIPAA). 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 re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer by protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. 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 Individual _____ Date _____

Name of Individual _____ Date _____

Signature of Personal Representative of Individual _____ Date _____

Description of Personal Representative's Authority _____