



Confidential Personal Data and Life Insurance Information

After receiving the following three pages of information, **The Rumson Group** will be able to evaluate the opportunity to present you with the current market value of your life insurance policy(s). Please complete all the required information in Sections 1, 2, & 3 and sign, where indicated, on page three. **Include with this application/authorization the following: a) current inforce illustrations; and b) current APS (attending physician statements).**

Medical, financial or other personal information that you provide will not be disclosed to any other person or entity without your specific written consent.

1. Personal Data

Name of Insured: _____ Social Security # _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (Daytime): _____ Telephone (Evening): _____

Date of Birth: _____ Marital Status: _____ Sex: Male Female

Second (2nd) Insured: _____ Social Security # _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (Daytime): _____ Telephone (Evening): _____

Date of Birth: _____ Marital Status: _____ Sex: Male Female

If policy owner is different than the above insured:

Name of Policy Owner: _____

Tax ID/Social Security # _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (Daytime): _____ Telephone (Evening): _____

2. Life Insurance Policy(s) Information (if more than two, attach extra sheet)

a) Name of Insurance Company: _____ Policy Number _____

Issue date: _____ Coverage/Face Amount: \$ _____

Amount of Premium: \$ _____ How frequently is Premium paid _____

Current Cash Surrender Value: \$ _____

Type of Policy (check): Term Whole Life Universal Life Other

b) Name of Insurance Company: _____ Policy Number _____

Issue Date: _____ Coverage/Face Amount: \$ _____

Amount of Premium: \$ _____ How frequently is Premium paid _____

Current Cash Surrender Value: \$ _____

Type of Policy (check): Term Whole Life Universal Life Other

3. Medical History

Please give a brief description of your medical condition:

Name of Physician seen for this medical condition: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Primary or Family Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Tips about Illustrations

Term Insurance

- Provide a current projection of the renewal premium schedule (not the guarantee schedule).
- Provide a conversion proposal for a universal life policy, showing the policy running to maturity. Preferably, not a variable UL, as the expense charges for a variable UL are typically higher.
- If term policy is convertible only to a whole life policy, then show the dividend option reducing the premiums, then excess to paid-up additions.

Universal Life Insurance

- Provide an inforce illustration to maturity.
- Additionally, it is helpful to attach an inforce illustration showing zero future premiums if there is a positive surrender value.

Whole Life Insurance

- Provide an inforce illustration, showing future dividends reducing the premium, with excess to paid-up additions.
- For non-participating policies (Stock Companies), there are no dividends, so just run the inforce illustration to maturity.
- It is rare that showing a surrender of dividends will be advantageous, because if there are accumulated dividends they are probably supporting paid-up additions.



THE RUMSON GROUP

This application, authorizations, current illustrations, and current APS should be mailed/faxed:

The Rumson Group LLC

261 Old York Road

Suite 808

Jenkintown, PA 19046

Telephone: (866) 886-9633

Fax: (215) 481-9990

Authorization For Disclosure Of Protected Health Information

I, the undersigned individual, authorize the 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 as follows:

- **Classes of Person 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 “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.
- **Classes of Person Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my PHI under this authorization to THE RUMSON GROUP LLC and it’s affiliates and any of their directors, officers, employees, agents, independent contractors, service providers, or other representatives (each, an Authorized Recipient).
- **Description of 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 to the Authorized Recipient 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 that THE RUMSON GROUP LLC shall broker to authorized funding institutions.
- **Expiration of Authorization:** This authorization shall remain valid until, and shall expire on, the date of my death.
- **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization 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 by 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.

- **Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization.** No HCP or other covered entity may condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

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 (the "HIPAA Privacy Regulations"). 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 my no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below 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

Signature of Personal Representative of Individual

Print or Type Name of Individual

Description of Personal Representative's Authority:
(Power of Attorney, Guardian at item or similar status)

Date Signed

Date Signed

I

THE RUMSON GROUP

The Rumson Group LLC
261 Old York Road
Suite 808
Jenkintown, PA 19046
Telephone: (866) 886-9633
Fax: (215) 481-9990

Authorization to Release Insurance Information

I hereby authorize my insurance company to furnish THE RUMSON GROUP LLC, or its authorized representatives, life settlement providers, or brokers, any information and forms they may request in connection to my policy (including any conversions thereof or replacements therefore).

I agree that a photo static copy or facsimile of this Authorization shall remain valid for four years, absent any provision of any applicable state statute or regulation to the contrary, in which event this authorization shall remain valid for the maximum period permitted there under.

I understand that all information will be kept strictly confidential.

NAME OF INSURED	SIGNATURE OF INSURED	DATE
NAME OF SECOND INSURED	SIGNATURE OF SECOND INSURED	DATE
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE
NAME OF OWNER (IF OTHER THAN INSURED)	SIGNATURE OF OWNER (IF OTHER THAN INSURED)	DATE
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE