Fifth Season Financial
*Funds for Living*

# FUNDS FOR LIVING APPLICATION

| **1. Applicant Information:** | | |
|---|---|---|
| First Name: | Last Name: | |
| Date of Birth: | Last 4 Digits of SSN: | Gender: □ Male □ Female |
| Residential Address: | | |
| City: | State: | Zip: |
| Phone: | Type of Phone: □ Mobile □ Home | |
| Email: | | |
| How did you hear about our program?: | | |

| **2. Medical Information:** |
|---|
| Type of Illness: |

| **3. Life Insurance Information:** |
|---|
| Life Insurance Carrier: |
| Face Value of Policy: $ |
| Is the life insurance policy owner different than the applicant? □ Yes □ No |

# APPLICANT ACKNOWLEDGEMENT

I, the Applicant and Insured and the Policy Owner (if different than the Applicant) of the Policy acknowledge and authorize the following:

1. The information provided in this application form is being submitted to Fifth Season to assist in the evaluation of my potential eligibility to use my Policy as collateral for a Fifth Season Funds for Living advance ("Advance"). I represent that all of the information provided in this application form is true and correct.
2. I consent and authorize Fifth Season to use this information, and any information I may provide on other forms, including Release of Information forms I may be asked to complete and sign during the evaluation and qualification process, regarding my Policy and medical history.
3. I consent to and authorize the release to Fifth Season of any information that it may request about me from any third parties, including insurance policy information and the release of my medical records from my physician(s) and any other of my healthcare providers (including pharmacy providers).
4. I consent to and authorize Fifth Season to conduct public record searches and background searches regarding myself including for purposes of insurance antifraud activity, and as necessary or required by Fifth Season to effect, administer or enforce the transaction contemplated by this application.
5. Instead of using my Policy to obtain an Advance, I may have other options available, including an accelerated benefits/living benefits option and an outright sale of the Policy. I understand that I should speak to my insurance company, insurance agent or financial planner with regard to other options available to me my under my Policy.
6. I understand that Fifth Season does not provide legal, tax or financial advice. As each individual situation is different, Fifth Season recommends that I speak with a legal, tax and/or estate planning advisor, concerning the merits of entering into an Advance and the tax consequences an Advance may have to me, my estate and/or heirs, including the potential tax consequences of debt forgiveness, if any.
7. One of the eligibility criteria to qualify for an Advance is for the Applicant to have a diagnosis of an advanced stage illness and a life insurance policy. I have been diagnosed as indicated above, have an existing life insurance policy and understand that not every individual living with an advanced stage illness or life insurance policy will qualify for an Advance.
8. I agree and consent to Fifth Season and its successors or assigns reproducing and transferring my signature in electronic form from the 'Authorization for Disclosure of Protected Health Information HIPAA Compliant' form or any other document signed by me to a HIPAA/Medical Release form mandated by a health care provider or facility holding any of my medical records, solely for purposes of obtaining such medical records from such health care provider or facility.

I HAVE READ AND UNDERSTAND:

_____ _____
Signature of Applicant/Insured DATE:

_____ _____
Signature of Policy Owner DATE:
(if different than Applicant)

# PHYSICIAN INFORMATION

Please provide the following information for the physicians you are currently seeing:

**Primary Oncologist or Disease Specific Specialist:** _____

**Physician Specialty:** _____

**Facility Name:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Date of Last Visit:** _____

**Primary Care Physician:** _____

**Physician Specialty:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Date of Last Visit:** _____

If you are seeing any other physicians, please share their details below:

**Physician Name:** _____

**Physician Specialty:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Date of Last Visit:** _____

**Physician Name:** _____

**Physician Specialty:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Date of Last Visit:** _____

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION HIPAA COMPLIANT

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI"), to specifically include the release of mental health, communicable disease (including HIV and AIDS) and drug and/or alcohol information, as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider (each, an "Authorized HCP"), or any Pharmacy Benefits Manager, insurance organization or covered entity having any PHI about me to disclose in written, electronic or verbal form 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. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization. This authorization allows for the disclosure, inspection, verbal discussion, and copying of any and all records, reports, and/or documents, including any underlying data, regarding my care and treatment and any other information in any Authorized HCP's possession concerning any treatment including planned course of treatment or hospitalization, including, but not limited to, all testing materials completed by or administered, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in any Authorized HCP's possession or control.

2. Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose and/or discuss my PHI under this authorization to a) Fifth Season Financial L.P., and its affiliated entities b) any life expectancy evaluator, c) any financing entity, lender and/or underwriter of Fifth Season Financial L.P. and its affiliated entities d) any person or entity that may seek to purchase any life insurance policy insuring my life, or loan secured by such policy, and e) any affiliated person or entity, business associate, agent, employee, representative, advisor, successor or assignee of any of the persons or entities covered in the immediately foregoing clauses a) through d) (each, an "Authorized Recipient"). Each Authorized Recipient in receipt of my PHI shall have the authority to, in turn, share and use my PHI as if it had been received directly from me.

3. 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. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with any life insurance policy, or certificate of life insurance, under which my life is insured, or any resale, assignment or other transfer of any such life insurance policy; (b) to negotiate and enter into relevant financing and related agreements and/or to develop and use indices related to actual and anticipated longevity, mortality, life expectancies and/or similar arrangements; (c) to maintain, manage and, possibly sell, transfer or assign any relevant finance arrangement: (d) 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; and (e) to comply with any judicial, legal or regulatory process.

4. Expiration of Authorization. This authorization shall remain continuously valid until, and shall expire on, the date that is five (5) years after the date of signature, unless such earlier expiration is required by applicable state law.

5. Right to Revoke Authorization. I acknowledge and understand that I may revoke this authorization any time with respect to, Fifth Season Financial L.P., and its affiliated entities by notifying Fifth Season Financial L.P. in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by Fifth Season Financial L.P.; provided, that, any revocation of this authorization shall not apply to the extent that Fifth Season Financial L.P. and its affiliated entities 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 Benefits on Provision of Authorization. I understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

7. California Residents Only: Mental Health Information. The PHI that may be disclosed pursuant to this Authorization includes records or information obtained by an Authorized HCP in the course of providing inpatient or outpatient services for mental health or developmental disabilities in any institutional or community mental health clinic setting. Such records may be disclosed without regard as to whether the treatment described in this paragraph was furnished on a voluntary or involuntary basis.

8. Authorization Not Requested by Health Care Provider, Clearinghouse or Plan. I understand that this authorization is at my request and not a consent of an authorization requested by a health care provider, health care clearinghouse or health plan covered by privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations") HIPAA privacy Regulations.

9. Potential for Re-disclosure. 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 be protected by the HIPAA Privacy Regulations.

10. Certification. 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.

SIGNED BY: _____

***Please ensure your signature is within the box and does not go over the outline of the box***

DATE SIGNED: _____

PRINT NAME: _____ DATE OF BIRTH: _____

# LIFE INSURANCE CARRIER RELEASE FORM

To: _____
Name of Life Insurance Carrier

Policy Number: _____ (the "Policy")

Name of Insured: _____

Name of Policy Owner: _____

**Re: Authorization to release policy information**

The undersigned, as owner of the Policy identified above, hereby certifies, intending that this notice may be relied upon by the insurance company or plan administrators which are obligated to pay or facilitate the payment of the related death benefits upon the death of the related insured by the terms of such Policy (or the successor to such obligation) and any other person or entity to which it shall be provided without any further enquiry, that:

1) Fifth Season Financial, L.P., and/or its authorized employees, representatives or assignees has the full authorization of the undersigned to correspond and communicate with third parties, including the insurance carriers and or group plan administrators regarding the Policy in all respects and to obtain any information including, but not limited to, in-force illustrations, verification of coverage, annual statements pertaining to the Policy, rider information, waiver of premium status and to have access to online information provided on the Policy, if available.

2) Nothing herein gives Fifth Season Financial, L.P., and/or its authorized employees, representatives, or assignees the right to sign documents on behalf of the undersigned or the Owner; and

3) A copy of this authorization may be relied upon by the insurance carriers or group plan administrators for all purposes.

DATED: _____

By: _____
Signature of Policy Owner

**CONFIDENTIALITY AND PRIVACY POLICY**

Fifth Season Financial LP, referred to as the "Company," is a business that necessarily acquires and maintains nonpublic personal information (including, without limitation, highly sensitive medical and personal information) about our potential applicants, actual applicants and customers. Although the Company is not a covered entity for purposes of the Health Insurance Portability and Accountability Act of 1996 and the Promulgated Privacy regulations ("HIPAA"), the company does obtain, use and disclose protected health information ("PHI") and personal financial information ("PFI") in order to conduct business and thus has implemented this privacy policy ("Policy") to safeguard PHI and PFI. All employees are expected to adhere to this internal Policy. This information is collected from the following sources:

- Applications or other forms completed by a consumer;
- Information a consumer authorizes the Company to receive from medical providers, insurance companies, and/or other authorized third parties; and
- Other information provided by a consumer (whether written or verbal).

The information referenced above is collected for the purpose of evaluating whether to extend a consumer loan and to administer such loan, if extended. The Company is dedicated to maintaining our consumers' privacy while their nonpublic personal information is in our hands. Our employees and contractors are permitted to use our consumers' nonpublic personal information only for approved Company business purposes. Employees and contractors are required to execute a confidentiality agreement protecting consumers' nonpublic personal information, as a necessary condition of employment or engagement with the Company.

We will use a consumer's nonpublic personal information as needed to complete the business tasks requested by such consumer, and will not share the consumer's (or a former customer's) nonpublic personal information with any non-affiliated third party serving in a non-representative capacity, except as required or permitted by law, authorized in writing by the consumer, or in the event the loan is sold to a third party. Specifically, information may be disclosed to the Company's affiliates, third party service providers as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes or to a new owner. However, we require any such affiliate, third party service provider or new owner to agree to safeguard the information, maintain its confidentiality, use the information only for the intended purpose, and abide by applicable law.

We employ and maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard our consumers' nonpublic personal information and restrict its disclosure to those in the Company, its contractors, affiliates or third party service providers who need to know such information in order to provide those products and services a consumer requests.

Employees and contractors are required to comply with all Company policies and procedures regarding the use, safeguarding, retention, and destruction of consumer nonpublic personal information, both in hard copy or paper form and in electronic form, including electronic images.

The Company will dispose of its records that contain nonpublic personal information by modifying the information to make it unreadable or undecipherable. We may make nonpublic personal information unreadable or undecipherable by erasing, shredding, or other means. We may also dispose of nonpublic personal information by contracting with a third-party vendor engaged in the business of disposing of records (in the same manner described above) that contain nonpublic personal information.

We are committed to protecting our consumers' nonpublic personal information in every transaction, at every level of our organization. The Company, its employees, contractors, affiliates and third-party service providers will maintain both consumer and business information in a secure, private, and confidential environment, and will strive to protect all such information from improper use or distribution.