

Initial Application for a LIFETRUST, LLC Line of Credit*

You agree to freely providing the following information to find out if you could qualify for the LIFETRUST, LLC (LIFETRUST) line of credit. This information will permit LIFETRUST to evaluate your interest in utilizing your life insurance policy as collateral for a line of credit.

You consent to and authorize LIFETRUST to use this information, and any information you provide on other Release of Information forms (ROI) which you may be asked to complete and sign during the evaluation and qualification process, to seek details and records from any third parties regarding your insurance policy and medical history. This may include your Insurance Policy carrier and its representatives; your physician(s) and any other of your healthcare providers or facilities. UNTIL YOU HAVE COMPLETED AND SIGNED THE ROI FORMS (ONE FOR THE INSURANCE AND ONE FOR MEDICAL RECORDS), WE WILL NOT CONTACT ANY OF THE THIRD PARTIES YOU HAVE PROVIDED.

Primary Oncologist: _____

Facility where I see them: _____

Telephone Number used to reach them: _____

I understand that the following disclaimers are provided for my benefit and should be given serious consideration prior to taking any action:

To qualify for the line of credit from LIFETRUST I am aware that I must have a diagnosis of cancer**. It is my understanding that the doctor diagnosed me to have:

Type of cancer: _____ Date Diagnosed: _____

I am aware that, rather than using my life insurance policy to secure a line of credit from LIFETRUST, I have other options available to me. These include, living benefit/accelerated benefit options and outright sale of the policy. I understand that I should contact my insurance agent or the insurance company regarding other options available to me from my policy.

I further understand that LIFETRUST, LLC wants me to make informed decisions. For this reason, they have advised me to seek professional guidance from my financial, tax and legal counselors regarding the merits of securing a line of credit.

I HAVE READ AND UNDERSTAND: _____ Date: _____

(Signature of Applicant/Insured)

(Print the Applicant/Insured's Name)

Address: _____

Telephone Number: _____

Best time to reach you: _____

City: _____

Time Zone: _____

State/Zip Code: _____

If Policy Owner is other than the Insured, please add the following information:

(Signature of Owner)

(Print the Name of the Owner)

Address: _____

Telephone Number: _____

Best time to reach you: _____

City: _____

Time Zone: _____

State/Zip Code: _____

* A line of credit from LIFETRUST is available in most states. Interest rate may vary by state of residency. ** Not every cancer patient will qualify. Generally, to meet the medical eligibility requirements, depending on the type of cancer, one or more of the following would most likely signify eligibility; disease recurrence, development of distant metastases or disease that has become unresponsive to treatment.