

Settlement Application

Life Insurance Policy Information

Insurance Company Policy Number Issue Date

Face Amount Total Policy Loan Cash Surrender Value

Annual Premium Payment Next Premium Due Date

Last Premium Paid Date Amount Paid

Yes No If yes, explain:
Are there any liens against the policy?

Annual Semi-annual Quarterly Monthly
Premium Mode

Term UL WL SUL SWL VUL Other (please specify):
Type of Policy

Individual Group Converted Group
Group or Individual Policy

Policyowner(s)

Name of Policyowner(s) Date(s) of Birth

Driver's License Number(s) SSN(s) or TIN

Name of President (if Corporate owned) Name of Corporate Secretary

Name of Trustee(s) if Trust Owned Date of Trust

Daytime Telephone Number Evening Telephone Number

Address

City State Zip

If there are multiple owners, please attach an additional page including full name of the owner(s), date of birth(s), driver's license number(s), social security or tax ID number(s), address(s) and telephone number(s) with area code(s).

If more than one policy is being submitted, please attach an additional page including policyowner(s) and life insurance policy information as requested above.

BBG/CPS

5750 Old Orchard Rd, Suite 350, Skokie, IL 60077

Ph: (800) 645-4700 Fx: (847) 965-8586

BBG/CPS

Names and ages of children, designated heirs and other dependents (if none, state "NONE")

Yes No

Have you been party to a bankruptcy since this policy issue date?

Married Divorced Legally Separated Widowed

Marital Status

Yes No

Is the policy subject to liens?

Yes No If no, what country?

Are you a U.S. Citizen?

Yes No If yes, please list below

Are you the owner of any other inforce life insurance policies?

Company Face Value

Company Face Value

Insured Personal Data

First Insured Name Date of Birth Sex

First Insured Social Security Number Drivers License Number

Daytime Telephone Number Evening Telephone Number

Yes No If no, what country?

Are you a U.S. Citizen?

Second Insured Name Date of Birth Sex

Second Insured Social Security Number Drivers License Number

Daytime Telephone Number Evening Telephone Number

Yes No If no, what country?

Are you a U.S. Citizen?

Address

City State Zip

Reason for Sale

First Insured Medical Condition (Brief Description)

Second Insured Medical Condition (Brief Description)

Yes No If yes, please list below:

Do you have any other life insurance policies in force?

Company Face Value

Company Face Value

Company Face Value

Medical Information

Name of Primary Physician Telephone with Area Code

Address

City State Zip

Name of Specialist Physician Specialty Telephone with Area Code

Address

City State Zip

If there are any other physicians who have treated you in the last five years, please attach an additional page including full name of physician's, specialty, address, and telephone number with area code.

Second Insured (if joint policy)

Name of Primary Physician Telephone with Area Code

Address

City State Zip

Name of Specialty Physician Specialty Telephone with Area Code

Address

City State Zip

If there are any other physician(s) who have treated you in the last five years, please attach an additional page including full name of physician's, specialty, address, and telephone number with area code.

The following will be needed to obtain an offer

Copy of the insurance policy if available or a copy of the face page

Inforce illustrations showing zero cash value at maturity

 If Universal Life policy, show minimum premium payments

 If Term policy, submit a current illustration and a conversion illustration to a permanent policy, showing minimum premium payments

 If Whole Life policy, run a vanishing premium illustration.

Medical records for the last five years, including family history. BBG/CPS can obtain records with an authorization.

Authorizations to release medical records and policy information

If policyowner has ever been bankrupt, include a copy of the bankruptcy discharge.

If policyowner has ever been divorced, include a copy of the divorce decree

In some cases, the following may be requested; updated medical records, doctors' notes, test results or alternative illustrations.

Signature of Insured Date

Signature of Second Insured Date

Signature of Policyowners Date

To facilitate execution, this application may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart hereof, and it shall be sufficient that the signature on behalf of each party appear on one or more.

Authorization

Please include this authorization to release records and policy information with this application

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an "Authorized Discloser") to provide Brown, Brown & Gomberg/CPS and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives of BBG/CPS, any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to BBG/CPS results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by BBG/CPS in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment)

I hereby authorize my insurance company to furnish BBG/CPS with any information or forms in connection with any life insurance policy under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of 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 (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

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 "HIPPA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser to BBG/CPS may be redisclosed by BBG/CPS and may no longer be protected by the HIPPA 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 I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

Authorized Disclosures:

| | | |
|---------------------------------------|---|------|
| Name of Insured | Signature of Insured | Date |
| Date of Birth | Social Security Number | |
| 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 |

To Carrier: _____

Re Policy: _____

Insured: _____

To Whom It May Concern:

This will authorize you to discuss and provide any policy information to _____ and the staff of Brown, Brown & Gomberg on any and all matters concerning my insurance with your company. He is presently reviewing and consulting with me re: my personal insurance.

You may send all information, forms, etc. directly to them as requested.

Signature of Policy Owner

Date

Print Policy Owner Name

(A photocopy or facsimile of this form shall be valid as the original.)

Policy Ledger Request

To Carrier: _____

Re Policy: _____

Insured: _____

To Whom It May Concern:

- This authorizes your company to illustrate the below requested scenarios and provide any policy information to the staff of _____ on any and all matters concerning my insurance with your company. They are presently reviewing and consulting with me regarding my personal insurance.

You may send all information, forms, illustrations etc. directly to them as requested.

Illustrate Following Scenarios:

1. _____

2. _____

3. _____

Signature or Policy Owner

Date

Print Policy Owner Name

(A photocopy or facsimile of this form shall be valid as the original.)