LIFE SETTLEMENT QUALIFIER

COVENTRY DIRECT
REDEFINING INSURANCE®

SECTION 1 PRIMARY CONTACT

Name of person completing qualifier _____ Today's date _____

Relationship to insured _____ Email _____

Primary phone number (_____) _____ Best time to call ☐ morning ☐ afternoon ☐ evening

SECTION 2 POLICY DETAILS

Life Insurance Policy Information *(If more than one policy is being submitted, please attach additional page(s) as necessary.)*

1. Insurance company _____ Policy number _____
2. Face amount _____ Cash surrender value _____ Approximate issue date/year _____
3. Type of policy ☐ term ☐ universal life ☐ whole life ☐ survivorship universal life ☐ survivorship whole life ☐ variable universal life ☐ group ☐ other *(please specify)* _____

   If policy is term, is it convertible? ..... ☐ YES ☐ NO ☐ I DON'T KNOW
4. Have you been notified that the policy is in a grace period or that the policy will lapse soon? ..... ☐ YES ☐ NO ☐ I DON'T KNOW
5. Total amount of death benefit in force on the insured listed in section three _____
6. Total number of policies in force on the insured listed in section three _____

SECTION 3 INSURED LIFESTYLE DETAILS

For survivorship policies, please complete separate qualifier for second insured. *(Please attach additional page(s) as necessary.)*

Name _____ Phone number (_____)_____

Address _____ City _____ State _____ ZIP _____

Height _____ Weight _____ Social security number _____ Date of birth _____ Sex ☐ male ☐ female
MM/DD/YYYY

1. Are you a U.S. citizen? If no, provide country of citizenship _____ ☐ YES ☐ NO
2. Do you live with anyone? If yes, provide relationship ☐ spouse ☐ significant other ☐ other _____ ☐ YES ☐ NO
3. Are you the primary caregiver for a dependent family member? ..... ☐ YES ☐ NO
4. Do you live in one of the following? ☐ assisted living facility ☐ skilled nursing facility or nursing home ☐ other_____ ☐ YES ☐ NO

   If yes, approximately how long have you lived there? _____
5. Do you require assistance to perform any of the following activities? *(Please check all that apply.)* ..... ☐ YES ☐ NO
   ☐ meal planning ☐ taking medication ☐ shopping ☐ walking ☐ bathing ☐ dressing

   If yes, provide details regarding why assistance is needed _____
6. After you fall asleep at night, on average, how many times (if any) do you typically get up? _____
7. Do you drive? If no, provide year and reason you stopped driving _____ ☐ YES ☐ NO

   _____
8. Approximately how often do you see your primary care physician? _____

   Approximately how often do you see specialists, such as a cardiologist or orthopedist? _____

   Are you currently choosing not to see doctor(s) or choosing not to follow a doctor's instruction? If yes, provide details ____ ☐ YES ☐ NO

   _____
9. Has your weight changed in the last year? If yes, provide details _____ ☐ YES ☐ NO
10. Do you engage in sports or regular exercise? If yes, provide type and frequency _____ ☐ YES ☐ NO

    _____

SECTION 3 INSURED LIFESTYLE DETAILS (continued)

11. Are you currently employed? If yes, provide occupation, job duties and hours per week _____ ☐ YES ☐ NO

_____

If no, provide the year you were last employed, field of work and job duties _____

_____

12. Are you involved in hobbies, clubs, charitable or religious organizations, travel or volunteer work? _____ ☐ YES ☐ NO

If yes, provide type and frequency _____

13. Have you ever smoked cigarettes? ☐ currently smoke ☐ previously smoked and quit ☐ never smoked

If you currently smoke or previously smoked, provide number of years _____ cigarettes per day _____

If you quit smoking, approximately how many years ago did you quit? _____

14. Do you use any other form of tobacco or nicotine? If yes, provide type and frequency _____ ☐ YES ☐ NO

15. Do you drink alcoholic beverages? If yes, provide type and frequency _____ ☐ YES ☐ NO

SECTION 4 MEDICAL HISTORY, CONDITIONS AND TREATMENTS

Have you ever been diagnosed with OR treated for any of the following conditions?
(Please check all that apply and provide details at the end of section four on page three.)

1. Disease or disorder of the heart? ☐ YES ☐ NO
   ☐ high blood pressure ☐ atrial fibrillation ☐ irregular pulse or arrhythmia other than AFIB ☐ coronary artery disease
   ☐ angina (chest pain from heart disease) ☐ heart attack(s) ☐ heart valve disease ☐ heart failure ☐ other
2. Circulatory or blood vessel disorder? ☐ YES ☐ NO
   ☐ stroke ☐ TIA or mini-stroke ☐ aneurysm of an artery ☐ arterial blockage in the neck, abdomen or legs
   ☐ venous disease such as blood clots, deep vein thrombosis or embolism ☐ other
3. Cancer? *(not including non-melanoma minor skin cancer)* ☐ YES ☐ NO
   ☐ tumor or malignancy ☐ leukemia ☐ lymphoma ☐ multiple myeloma ☐ blood cancers (MPNs)
   ☐ myelodyplastic syndrome ☐ other cancerous disorder

In the past five years, have you been diagnosed with OR treated for any of the following conditions?
(Please check all that apply and provide details at the end of section four on page three.)

4. Neurological disorder? ☐ YES ☐ NO
   ☐ Parkinson's disease ☐ multiple sclerosis ☐ ALS (Lou Gehrig's disease) ☐ loss of consciousness ☐ convulsions or epilepsy
   ☐ poor vision ☐ chronic pain ☐ sleep apnea ☐ other
5. Mental or nervous disorder? ☐ YES ☐ NO
   ☐ memory or cognitive impairment without dementia ☐ Alzheimer's or other type of dementia ☐ depression
   ☐ schizophrenia ☐ other
6. Disease or disorder of the digestive system? ☐ YES ☐ NO
   ☐ diabetes ☐ liver (not due to infection) ☐ colon or rectum ☐ small intestine ☐ esophagus or stomach
   ☐ GI bleeding (upper or lower) ☐ other
7. Infectious disease? *(other than common cold or flu)* ☐ YES ☐ NO
   ☐ hepatitis ☐ pneumonia ☐ sepsis (blood infection) ☐ shingles ☐ urinary tract infection ☐ MRSA ☐ other
8. Disease or disorder of the lungs or respiratory system? ☐ YES ☐ NO
   ☐ asthma ☐ COPD, emphysema or chronic bronchitis ☐ shortness of breath at rest or with minimal exertion
   ☐ chronic lung infection ☐ other
9. Genitourinary problems, disease or disorder? *(other than cancer)* ☐ YES ☐ NO
   ☐ prostate ☐ bladder ☐ kidney disease, impaired function or failure ☐ urine abnormalities ☐ other
10. Abnormality of the blood, platelets or blood forming organs? ☐ YES ☐ NO
    ☐ anemia ☐ high cholesterol or triglycerides ☐ abnormalities of platelets, white or red blood cells
    ☐ abnormal bruising, bleeding or clotting ☐ disorder of the spleen, bone marrow or lymph nodes ☐ other
11. Bone, joint or nerve abnormality, injury or accidental fall? ☐ YES ☐ NO
    ☐ paralysis or significant physical impairment ☐ gout ☐ numbness in extremities ☐ problems with balance or walking
    ☐ injury or accidental fall ☐ degenerative arthritis ☐ rheumatoid arthritis ☐ osteoporosis
    ☐ fracture of hip, vertebra or other bone ☐ other

SECTION 4 MEDICAL HISTORY, CONDITIONS AND TREATMENTS (continued)

12. Immune system disorder? ..... ☐ YES ☐ NO
    ☐ HIV ☐ autoimmune disease ☐ systemic lupus ☐ connective tissue disease ☐ other
13. Alcohol and drug use? ..... ☐ YES ☐ NO
    ☐ alcoholism or alcohol abuse ☐ illegal drug use ☐ marijuana ☐ prescription drug abuse
    ☐ ever been advised by a medical professional to reduce or eliminate alcohol or drug use, including prescription drugs
14. Have you ever had a transplant of any organ or tissue, been diagnosed with, been treated for, had surgery, or are currently being treated for any other disease or disorder, or had an accident or injury not previously listed? ..... ☐ YES ☐ NO
15. Health screen history *(if known)*
    Blood pressure _____/_____ Blood tests: Cholesterol _____ Blood sugar _____ Ejection fraction _____

DETAILS

For any condition checked in section four, please provide full details including diagnosis, date of diagnosis, type of treatment(s) received, date last treated, results and additional details. *(Please attach additional page(s) as necessary.)*

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY
Type of treatment received _____ Date last treated _____ MM/DD/YYYY
Results _____

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Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY
Type of treatment received _____ Date last treated _____ MM/DD/YYYY
Results _____

Diagnosis _____ Date of diagnosis _____ MM/DD/YYYY
Type of treatment received _____ Date last treated _____ MM/DD/YYYY
Results _____

SECTION 5 FAMILY HISTORY AND PRESCRIPTION MEDICATION

1. Family History *(Include full and half sibling(s) and biological children only.)*

	Age, if living	Age at death, if deceased	Cause of death	
Mother	_____	_____	_____	
Father	_____	_____	_____	
Sibling	_____	_____	_____	☐ male ☐ female
Sibling	_____	_____	_____	☐ male ☐ female
Sibling	_____	_____	_____	☐ male ☐ female
Spouse	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female
Child	_____	_____	_____	☐ male ☐ female

SECTION 5 FAMILY HISTORY AND PRESCRIPTION MEDICATION (continued)

2. Do you take any medications currently? ☐ YES ☐ NO

Please include over-the-counter (OTC) medications and vitamins. *(Please attach additional page(s) as necessary.)*

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Medication name _____ How long prescribed _____

For what condition _____ Dosage and frequency _____

Do you use any non-prescription alternative treatments such as herbal remedies? If yes, indicate type and frequency _____ ☐ YES ☐ NO

_____

SECTION 6 PHYSICIAN INFORMATION

1. Primary Care Physician

Name _____ Phone (_____) _____

Address _____ City _____ State_____ ZIP_____

Approximate date of last visit_____ (MM//YYYY) Reason for last visit _____

2. Specialty Care Physicians

List those who have treated you in the last five years. *(Please attach additional page(s) as necessary.)*

Name _____ Phone (_____) _____

Address _____ City _____ State___ ZIP_____

Approximate date of last visit_____ (MM//YYYY) Reason for last visit _____

Name _____ Phone (_____) _____

Address _____ City _____ State_____ ZIP_____

Approximate date of last visit_____ (MM//YYYY) Reason for last visit _____

Name _____ Phone (_____) _____

Address _____ City _____ State_____ ZIP_____

Approximate date of last visit_____ (MM//YYYY) Reason for last visit _____

Coventry Direct LLC ("Coventry Direct") is a marketing company and not a life settlement provider or broker. Coventry Direct will refer qualified policies to a licensed entity which may or may not be affiliated with Coventry Direct.

I hereby acknowledge that Coventry Direct may provide this qualifier and any and all information provided herein, including my personal and/or health related information, to Coventry Direct's affiliates, as well as non-affiliated contracted parties, for the purpose of evaluating and qualifying for a life settlement, one or more life insurance policies under which my life is insured.

I hereby represent and warrant that any and all information provided by me in this qualifier is true and correct as of the date hereof. I hereby affirm my understanding that Coventry Direct, any of its affiliates, and/or any of their respective directors, officers, employees, agents, independent contractors, service providers or other authorized representatives (each, an "Indemnified Person") will be relying on the statements and responses made by me in this qualifier, and I agree to hold each Indemnified Person harmless and agree to indemnify each Indemnified Person from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

Name of insured | Signature of insured | Date

AUTHORIZATION

(Please sign this authorization to release medical and policy information.)

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefits manager, hospital, clinic and/or any other healthcare provider identified below (each, an "Authorized Discloser") to provide Coventry Direct LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives ("Coventry"), 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 Coventry the 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 Coventry in connection with the evaluation and qualification for a life settlement or other mortality-based product. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

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

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser or Coventry 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 healthcare provider, healthcare 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, any of my medical information disclosed by any Authorized Discloser to Coventry may be redisclosed by Coventry and may 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 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 disclosers _____

_____

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

This authorization 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 and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.