backnine insurance

SIMPLIFIED SETTLEMENT QUESTIONNAIRE

(Please print clearly)

Insured Medical Information

1. Name of insured _____ date of birth_____/_____/_____

2. Height _____ weight _____ sex (male / female) _____ social security number _____

Insured's Lifestyle and Habits

3. ❑ Yes ❑ No Has your weight changed in the last year?

   If yes, provide details: _____

4. ❑ Yes ❑ No Do you currently, or have you ever smoked cigarettes?

   If yes, date of last use (if currently smoking, write "current"): _____ How long prior to this date did you smoke? _____ Indicate how many daily: _____

5. ❑ Yes ❑ No Do you use any other form of tobacco?

   If yes, indicate type and frequency: _____

6. ❑ Yes ❑ No Do you drink beer, wine or spirits?

   If yes, indicate type and amount of drinks consumed per day: _____

7. ❑ Yes ❑ No Are you currently employed?

   If yes, indicate occupation: _____

8. ❑ Yes ❑ No Are you involved in hobbies, clubs, organizations or volunteer work?

   If yes, provide details of type and frequency: _____

9. ❑ Yes ❑ No Do you have a valid driver's license?

10. ❑ Yes ❑ No Do you currently engage in sports or regular exercise?

    If yes, provide details of type and frequency: _____

11. ❑ Yes ❑ No Do you live alone?

    If no, do you live with a spouse or significant other: _____

12. ❑ Yes ❑ No Do you live in an assisted living facility or nursing home?

13. ❑ Yes ❑ No Are you the primary caregiver for a dependent family member?

    If yes, provide details: _____

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14. ❑ Yes ❑ No Do you require assistance to perform any of the following activities? **(circle all that apply)**

meal planning taking medication driving shopping

walking bathing dressing

If yes, provide details: _____

15. ❑ Yes ❑ No Do you use any non-prescription alternative treatments such as herbal remedies?

If yes, provide details of type and frequency: _____

Medical History, Conditions and Treatments

In the past five years, have you been diagnosed with or treated for any of the following conditions? **(circle all conditions that apply)**

16. ❑ Yes ❑ No Disease or disorder of the heart including high blood pressure, irregular pulse, heart attack, coronary artery disease, chest pain, angina or other heart disorder?

17. ❑ Yes ❑ No Circulatory or blood vessel disorder, including stroke, TIA (mini-stroke), arterial blockage in the neck, abdomen or legs, blood clots, aneurysm or any other?

18. ❑ Yes ❑ No Cancer, tumor or malignancy? (please provide details below regarding exact type, stage, metastasis, treatment or surgery, results and any ongoing therapy)

19. ❑ Yes ❑ No Any immune system disorder?

20. ❑ Yes ❑ No Disease or disorder of the digestive system including diabetes, liver disease, colon, intestinal, stomach disorder or any other?

21. ❑ Yes ❑ No Infectious disease (other than common colds and flu) including hepatitis, pneumonia, sexually transmitted disease, shingles or any other?

22. ❑ Yes ❑ No Disease or disorder of the lungs or respiratory system including asthma, emphysema, COPD, chronic bronchitis, shortness of breath or any other?

23. ❑ Yes ❑ No Genitourinary problems including disease or disorder of the genitalia, breasts, prostate, bladder, kidney or any other?

24. ❑ Yes ❑ No Abnormality of the blood and platelets including anemia, high cholesterol or any other?

25. ❑ Yes ❑ No Bone or joint abnormality, paralysis, trauma, injury or physical impairment, including problems with balance or walking?

26. ❑ Yes ❑ No Neurological disorders including Parkinson's disease, multiple sclerosis, loss of consciousness, convulsions or epilepsy, loss of vision or hearing, neuropathy, chronic pain or any other?

27. ❑ Yes ❑ No Mental or nervous disorder including memory or cognitive impairment, dementia, psychiatric disorder or any other?

28. ❑ Yes ❑ No Have you ever been treated for alcohol or drug abuse, or told by a physician or practitioner to reduce or eliminate alcohol or drug use?

29. ❑ Yes ❑ No Have you been diagnosed with, been treated for, had surgery or are currently being treated for any other disease or disorder not previously given?

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If you answered "yes" to any of questions 16 - 29, please provide details below. **(attach an additional page if necessary)**

question #_____ diagnosis _____ date of diagnosis____/____/____

date last treated____/____/____ name of physician or hospital _____ results _____

question #_____ diagnosis _____ date of diagnosis____/____/____

date last treated____/____/____ name of physician or hospital _____ results _____

question #_____ diagnosis _____ date of diagnosis____/____/____

date last treated____/____/____ name of physician or hospital _____ results _____

Family History, Prescription Medications and Physician Information

30. Mother's age, if living _____ if deceased, age at death _____ cause of death _____

31. Father's age, if living _____ if deceased, age at death _____ cause of death _____

32. Sibling(s) age(s), if living _____ if deceased, age(s) at death _____ cause of death(s) _____

33. Please list all prescription medications currently being used:

_____

_____

34. Please provide the name and address of your primary care physician, noting date and reason last seen:

name _____ address _____

date last seen ____/____/____ reason for visit _____

The undersigned insured and agent hereby represent and warrant that any and all information provided in this questionnaire is true and correct as of the date hereof. Each undersigned hereby affirms its understanding that BackNine Insurance will be relying on the statements and responses which are being provided by the undersigned in this questionnaire, and each undersigned agrees, jointly and severally, to hold BackNine Insurance harmless and agrees to indemnify BackNine Insurance from and against any loss, liability, expense, claim or demand arising out of or in connection with any such statement or response.

I UNDERSTAND THAT IT IS A CRIME TO KNOWINGLY PRESENT FALSE, INACCURATE, INCOMPLETE OR MISLEADING INFORMATION TO, OR CONCEAL INFORMATION RELATED TO AN APPLICATION FOR INSURANCE OR FOR A LIFE SETTLEMENT FROM, AN INSURANCE COMPANY OR A LIFE SETTLEMENT PROVIDER FOR THE PURPOSE OF DEFRAUDING SUCH COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF BENEFITS AND CIVIL DAMAGES. I UNDERSTAND THAT BACKNINE INSURANCE HAS IN PLACE ANTI-FRAUD INITIATIVES DESIGNED TO DETECT AND PREVENT FRAUD, AND MAY REPORT CASES OF SUSPECTED FRAUD TO THE APPROPRIATE LEGAL AND REGULATORY AUTHORITIES OR INSURANCE COMPANIES.

_____

name of insured | signature of insured | date

_____

name of agent | signature of agent | date

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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 BackNine Insurance 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 BackNine Insurance 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 BackNine Insurance in connection with the decision to finance, 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 BackNine Insurance 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 "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Discloser to BackNine Insurance may be redisclosed by BackNine Insurance 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

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 such counterparts.

BackNine Insurance • 310 N. Westlake Blvd, Suite 240 • Westlake Village, CA 91362

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