

# LIFE SETTLEMENT SUBMISSION CHECKLIST

The following requirements are needed to submit a life settlement case for review.

- Dunhill Life Settlement application completed in full (attached).
- Dunhill Authorization (HIPAA) Form.
- Agent & Broker of Record Form.
- Medical records for the last 5 years with family history. If unable to obtain this information, Dunhill will order the records.
- Current in-force illustration showing zero cash value 5 years from current date, 10 years from current date and \$0 cash at age 100.
- Copy of the face page of the policy.

In addition to the above, complete ONE of the following based on your policy face value:

- Policies up to \$500K – Complete the Coventry Medical Settlement Questionnaire
- Policies over \$500K and up to \$5M – Complete the Fast & Easy Settlement Quotes

**NOTE regarding Life Expectancy Reports:**

- For policies greater than \$500,000 - Dunhill will pay for the life expectancy report.

# CONFIDENTIAL APPLICATION

Please complete in full.

## INSURED'S INFORMATION

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Street Address (No PO Box): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Fax #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Female Male  
Spouse's Full Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## EMPLOYMENT STATUS

Are you currently retired? Yes No Do you work? Yes No  
Current employer and occupation: \_\_\_\_\_

## LIFE INSURANCE POLICY INFORMATION (please provide for all policies being offered)

Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Face Value: \$ \_\_\_\_\_  
Policy Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insuring: Individual Survivorship Group  
Policy Type: Universal Life Variable Universal Life Term Life Whole Life  
If a Term policy, what is the conversion date? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Annual Premium: \_\_\_\_\_ Paid: A SA Q M Next Premium Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Owner of Policy: \_\_\_\_\_  
Owner Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Complete Trust or Corporation name, and names of Trustee(s) or 2 officers:  
\_\_\_\_\_  
\_\_\_\_\_

Beneficiary (ies): \_\_\_\_\_  
Primary Beneficiary Address: \_\_\_\_\_  
Original purchase reason: Estate Planning Family Protection Buy/Sell Agreement Key Man  
Other (describe): \_\_\_\_\_  
Reason for Selling: \_\_\_\_\_  
Has insured ever been declined, rated or modified in any way when applying for life/health insurance? Yes No If Yes, please give company and reason: \_\_\_\_\_  
\_\_\_\_\_

Does Insured have plans to purchase new life insurance? Yes No

Total face value of insurance NOT being offered for sale herewith? \_\_\_\_\_

## MEDICAL HISTORY

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please list ANY specific conditions: \_\_\_\_\_

Has insured smoked? Cigarettes Cigars Pipe In the past 12 months? Yes No

Does insured use, or ever used, alcoholic beverages? Yes No If yes, please answer the following:

(1) Frequency of use: Daily Weekly Monthly Occasionally

(2) Amount consumed on each occasion: \_\_\_\_\_

(3) Any treatment for alcohol use (including AA): \_\_\_\_\_

### Family History

### Current Age

### Deceased

### Cause and age at time of death

Father	_____	Yes No	_____
Mother	_____	Yes No	_____
Brother/Sister	_____	Yes No	_____
Brother/Sister	_____	Yes No	_____

## INSURED'S PRIMARY CARE PHYSICIANS

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Please list ANY Specialists that insured has seen:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

## FINANCIAL

Has insured ever applied for or received a pension or compensation for illness or injury? Yes No

If yes, please give details: \_\_\_\_\_

Has owner ever been party to: Civil Suit Bankruptcy Judgments Tax/Creditor Liens

Please explain any checked answers on a separate sheet of paper and attach all discharge papers.

Does insured have a living will? Yes No

Owner's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_