AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

The undersigned insured ("I", "me", or "my") authorizes the disclosure of all my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:

1. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of healthcare provider (each, an "Authorized HCP") having any PHI about me, to disclose any and all my PHI as provided under this authorization. I acknowledge that all my PHI in the possession or control of any Authorized HCP is necessary for the purposes for which I have given this authorization as described below.

2. I authorize each Authorized HCP to disclose my PHI under this authorization to **PROSPERITY LIFE SETTLEMENTS**, any likened life settlement broker and licensed life settlement provider, their respective affiliates, subsidiaries, independent contractors, agents, representatives, service providers, and any of their respective successors, assigns, and any transferees of any life insurance policy insuring my life (each, an "Authorized Recipient").

3. This authorization shall apply to any and all my health and medical data, information, and records, whether personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing any Authorized Recipient (a) to analyze, assess, evaluate, or underwrite my health or medical condition, or my life expectancy, in connection with the possible sale of any life insurance policy insuring my life to any Authorized Recipient and (b) to monitor, track, or verify my health, life, or medical status and condition in connection with, and after the sale of, any life insurance policy insuring my life.

4. This authorization shall remain valid until, and shall expire on, the date that is one (1) year after the date of my death, or such other date, if any, as may be required by applicable law or regulation.

5. I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. No Authorized HCP or other covered entity may condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I specifically authorize and request each Authorized HCP to rely upon a photostatic of facsimile copy or other reproduction of this authorization. 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, there is the potential for my PHI that is disclosed by an Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations. I certify that I am executing and delivering this authorization freely. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for my future reference.

PLEASE REMIT ALL CORRESPONDENCE TO:
PROSPERITY LIFE SETTLEMENTS
660 BEACHLAND BLVD, SUITE 308
VERO BEACH, FL 32963
FAX# (888) 881-1681

INSURED (Policy Insured):

AGREED and ACCEPTED this _____ day of _____, _____.

Insured: _____ Printed Name: _____
signature

Date of Birth: _____ Social Security Number: _____