

SUBMITTED TO: _____ **NAIC#** _____

NAME OF INSURANCE COMPANY

POLICY NUMBER: _____

SUBMITTED FROM: _____

NAME OF VIATICAL SETTLEMENT BROKER/PROVIDER

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____ **TITLE:** _____

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by the Insurance Company
Owner's name:	*	
Address:	*	
City, state, ZIP code:	*	
Tax ID or Social Security number:	*	
Insured's name:	*	
Insured's date of birth:	*	
Second insured's name (if applicable):	*	
Second insured's date of birth (if applicable):	*	

Signature of policy owner

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IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR
PORIVDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

✻

If a question is not applicable to the type of policy, write N/A in the column.

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POLICY VALUES

	This column to be completed by Viatical Settlement Broker/provider	This column to be used by Insurance Company
Policy values as of:		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is the policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of:		
Date of last cost insurance deduction		

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

Signature

Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____ (date).

Insurance company: _____ NAIC# _____

Printed name: _____ Title: _____

Telephone number: _____ Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____ Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____ Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- ☐ Absolute Assignment/Change of Ownership/Viatical Assignment
- ☐ Change of Beneficiary
- ☐ Release of Irrevocable Beneficiary (if applicable)
- ☐ Waiver of Premium Claim Form
- ☐ Disability Waiver of Premium Approval Letter
- ☐ Release of Assignment
- ☐ Change of Death Benefit Option Form (if UL)
- ☐ Allocation Change form (if Variable)
- ☐ Annual Report
- ☐ Current In Force Illustration