

The Settlement Group, Inc.

300 Osborne Street • Saint Marys, GA 31558
912-882-0840 • Fax 912-882-0609 • www.lifsettlementgrp.com

CLIENT APPLICATION

Personal Information - Insured

Name: _____
First M. Last
Address: _____
Street Apt. #
City State Zip Code
Date of Birth: _____ Social Security # _____ - _____ - _____
Home phone (____) _____ - _____ Business Phone (____) _____ - _____
E-Mail: _____ Mobile Phone (____) _____ - _____
Single ___ Married ___ Divorced ___ Widowed ___ Dependent Children? Yes ___ No ___

How did you hear about SGI?

Employment - Insured (complete only if policy is group insurance)

Employer _____ Phone (____) _____ - _____
Currently working? Yes ___ No ___ Retired ___ Hire date ____/____/____ Retire date ____/____/____

Policy Information - Insured or Policy Owner

Life Insurance Company: _____ Phone (____) _____
Type of policy: Group ___ Individual ___ Converted Group ___ Conversion date ____/____/____
Whole Life ___ UL ___ Term ___ Joint ___ Survivorship _____
Policy number: _____ Face Amount of Policy: _____ Date of Issue: _____
Premium Amount \$: _____ Monthly ___ Quarterly ___ Semi-Annual ___ Annual ___
Are you the owner of this policy? Yes ___ No ___

If **not**, who is the owner? _____
Name DOB SSN Telephone (____) _____
Address City State Zip Code

Who is the beneficiary of this policy? _____
Name Relationship
Has the Policy Owner ever declared bankruptcy? Yes ___ No ___ Date _____

The Settlement Group, Inc.

300 Osborne Street • Saint Marys, GA 31558
912-882-0840 • Fax 912-882-0609 • www.lifeselementgrp.com

Medical Condition - Insured

What is your current medical condition? _____

Date of most recent visit to doctor: ____/____/____ To Hospital: ____/____/____

When were you first diagnosed? ____/____/____

_____ Physician Name	_____ Address	(____)____-____ Telephone
_____ Physician Name	_____ Address	(____)____-____ Telephone
_____ Physician Name	_____ Address	(____)____-____ Telephone

Please list all physicians and/or specialists treating you at this time. Include name, address, and phone number.

_____ Physician Name	_____ Address	(____)____-____ Telephone
_____ Physician Name	_____ Address	(____)____-____ Telephone
_____ Physician Name	_____ Address	(____)____-____ Telephone

Terms and Conditions

- A. The applicant warrants and represents that all information contained in this application is true and correct to the best of his/her knowledge.
- B. The applicant consents to be examined by SGI and it's agents and the redisclosure of any existing medical records. The applicant consents to SGI and it's agents of any and all information that SGI may request from the applicant or any third parties. The applicant will execute any documents necessary to allow SGI to conduct such examinations or to acquire such information.
- C. The applicant herein includes a photocopy of a driver's license or picture identification and swears and warrants that he/she is in fact that person so identified.