# FAX

| | | | |
|---|---|---|---|
| **To:** | Richard Winblad, Winblad Law PLLC | **From:** | |
| | | **Sender** | |
| **Fax:** | 1-866-712-1093 | **Phone:** | |
| **No. of** | | | |
| **Pages:** | | **Date:** | |
| | | **Sender** | |
| **Re:** | Life Care Funding Application | **Email:** | |

☑ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

**Comments:**

The information contained in this fax is private and confidential. In the event that it is received by an unintended recipient you are instructed to destroy to contents and notify the sender regarding the mistaken delivery. The information may also be covered by attorney-client privilege.

[Pick the date]

# Long Term Care Benefit Plan
## Benefit Qualification Form

Winblad Law, PLLC 405.340.6554 FAX 866.712.1093

**PERSONAL INFORMATION OF INSURED**

Name: _____

DOB: _____ Gender: _____ Marital Status: _____

Best contact person: _____ Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Best time to reach you: _____

Email address: _____

**POLICY INFORMATION**

Insurance Carrier Name: _____

Face amount (Death Benefit): _____ Annual Premium: _____

Outstanding Loan: _____ Beneficiary: _____

Type of Policy: ☐ Universal Life ☐ Whole Life ☐ Term Life ☐ Group Life ☐ Other

**MEDICAL INFORMATION**

Primary Care Physician's name and phone number:

Other physicians and specialists, please include their phone numbers:

List primary medical conditions:

**NEED FOR LONG-TERM CARE SERVICES**

☐ Assisted Living ☐ Homecare: Private Duty ☐ Homecare: Family Caregiver ☐ Skilled Nursing
☐ Memory Care ☐ Hospice

**TIMEFRAME FOR CARE:** ☐ Immediate ☐ Within 3 months ☐ Within 6 months ☐ Longer

**WHERE IS CARE CURRENTLY BEING RECEIVED OR WILL BE RECEIVED?**

☐ Facility ☐ Home (Please provide individual or vendor providing care and relationship)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Relationship: _____

Current resident of above? ☐ Yes ☐ No

Referred by: _____
Phone: _____

**NEED FOR ASSISTANCE TO PERFORM THE FOLLOWING ACTIVITIES OF DAILY LIVING? (check all that apply)**

☐ Walk ☐ Dress ☐ Grooming (combing and shampooing hair, shaving, brushing teeth)
☐ Transfer (ability to get in and out of a chair and/or bed) ☐ Bath/Shower
☐ Toileting (on and off, to and from) ☐ Incontinent Bladder ☐ Incontinent Bowel
☐ Eating (does not include meal preparation) ☐ Manage and take medications

**DOES THE INSURED HAVE ANY OF THE FOLLOWING DOCUMENTS IN PLACE?**

☐ Advanced Medical Directive/Living Will ☐ DNH (Do Not Hospitalize) Order ☐ Power of Attorney
☐ DNR (Do Not Resuscitate) Order ☐ Receiving Hospice Care

**FAMILY STORY**

Please provide as much background information on the current status of this case to help us understand the situation. Please include information regarding the insured's health and care needs including how they plan to utilize the proceeds from this transaction.

---

**NOTE SECTION / SPECIAL INSTRUCTIONS**

**Submitted by**

Contracted Professional _____ Email _____

Phone Number _____ Writing Number _____ Date _____

The information contained herein is complete and accurate and may be relied upon to determine eligibility and pricing factors for an intended Long-Term Care Benefit Plan.

**Please return completed Application and Authorizations to: (e) zbd@qcapital.com or (f) 561-886-4605**

# Long Term Care Benefit Plan

In order to process your application for a long term care benefit plan, we need you to read and sign the two (2) authorizations attached:

**A) The Life Insurance Information Release Form**

This release authorizes us to obtain information about your policy from your life insurer. We mostly need this information to determine the premiums due on your policy and make sure that your policy does not expire.

This release does NOT allow us to make any changes to your policy.

**B) Authorization for Disclosure of Protected Health Information**

This release authorizes us to request medical information from your doctor(s). Your privacy is important to us and we only use this data for the purpose of evaluating your health profile and need for care.

***Please note that signing these releases will not result in any costs you. The entire application process is free.***

***Also, there is NEVER any obligation to proceed with the benefit plan. You may withdraw your application at any time during the process.***

# Long Term Care Benefit Plan - Authorization

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, authorize disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

1. Classes or Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photo-static or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Life Care Funding, LLC and/or Q Capital Strategies, and any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not 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 purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore.

4. Expiration: this authorization shall remain valid until, and shall expire, one year after the date of my death.

5. Right to Revoke Authorization: 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 bu 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. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Health Plan Benefits on Provisions of this Authorization. No Authorized HCP or other covered entity may condition treatment, payment, enrollment or eligibility for health plan benefits on whether this authorization is signed or not.

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 (HIPAA). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer by protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. 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 future reference.

| | |
|---|---|
| Signature of Individual | Date |
| Name of Individual | Date |
| Signature of Personal Representative of Individual | Date |
| Description of Personal Representative's Authority | |

# Long Term Care Benefit Plan - Release Form

**LIFE INSURANCE INFORMATION RELEASE FORM**

Life Insurance Policy Number

Issued by

Is owned by

Insured the life of

I authorize the release to Life Care Funding, LLC and/or Q Capital Strategies or its designee, any or all information concerning the above policy.

Policy Owner Signature

Date

Type or Print Name

Policy Owner SSN#