

**State of California**  
**Department of Insurance**  
**Life Settlement Provider**  
**Annual Statement**  
(To be filed on or before March 1<sup>st</sup> of each year)

**1. FOR THE YEAR ENDING:**  
DECEMBER 31, \_\_\_\_\_.

**2. PROVIDER FEIN #:**  
\_\_\_\_\_

**3. LIFE SETTLEMENT PROVIDER INFORMATION:**

a. Full name of Life Settlement Provider, including all d.b.a.'s:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Organized under the laws of the State of:

\_\_\_\_\_

c. Date licensed as a Life Settlement Provider:

\_\_\_\_\_

d. Address of Provider's Administrative Office:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

e. Is the above address the location of all provider books and business records?

Yes.

No, the address to the location of all provider's books and business records is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

f. Provider's mailing address (if different from above):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

g. Name of contact person:

\_\_\_\_\_

h. Telephone number for contact person:

\_\_\_\_\_

**4. LIFE SETTLEMENT PROVIDER OWNERSHIP INFORMATION:** In the table below, list the name, title, percentage of ownership interest, business address, and residence address of each individual who is responsible for the conduct of the Life Settlement Provider's affairs, or has the ability to exercise significant control over the provider, including but not limited to officers, directors, trustees, partners, shareholders holding a ten percent (10%) or greater interest in provider and key personnel. Place an asterisk (\*) next to the name of any individual not reported on the most recent Annual Statement or application. Attach additional sheets if necessary.  Additional sheets attached.

NAME	TITLE	% OWN	BUSINESS ADDRESS	RESIDENCE ADDRESS

**LIFE SETTLEMENT PROVIDER’S ACKNOWLEDGMENT:** I declare under penalty of perjury that I am one of the above-described officers, owners, and/or general partners of

\_\_\_\_\_,  
(name of life settlement provider)

that I am responsible for conducting the business of the above-named life settlement provider and that the information contained in this Annual Statement, including all of its schedules, answers, explanations, and attachments, is complete and accurate to the best of my knowledge, information, and belief. *(Two signatures required.)*

By: _____ Printed Name: _____ Title: _____ Date: _____	By: _____ Printed Name: _____ Title: _____ Date: _____
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**5. POLICY INFORMATION:**

a. List the total number (nationwide) of life insurance policies settled during the immediately preceding calendar year: _____	b. List the aggregate face amount (nationwide) for policies settled during the preceding calendar year: \$_____
c. List the total number of life insurance policies settled in California during the immediately preceding calendar year: _____	d. List the aggregate face amount for policies settled with respect to California residents during the preceding calendar year: \$_____

<p>e. List the total number (nationwide) of life insurance policies settled involving a retained beneficiary during the immediately preceding calendar year: _____</p>	<p>f. List the aggregate face amount (nationwide) for policies settled involving a retained beneficiary during the immediately preceding calendar year: \$ _____</p>	
<p>g. List the aggregate premium commitment (nationwide) for policies settled involving a retained beneficiary during the immediately preceding calendar year: \$ _____</p>	<p>h. List the total number of life insurance policies settled in California involving a retained beneficiary during the immediately preceding calendar year: _____</p>	
<p>i. List the aggregate face amount for policies settled with respect to California residents involving a retained beneficiary during the preceding calendar year: \$ _____</p>	<p>j. List the aggregate premium commitment for policies settled with respect to California residents involving a retained beneficiary during the preceding calendar year: \$ _____</p>	
<p><b>6. Is the provider submitting its audited financial statement with annual statement?</b></p> <p>If NO, please ensure an audited financial statement is provided in accordance with Section 2548.15.</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>7. GENERAL INTERROGATORIES</b></p>		
<p>a. Has there been any change in the provider's name, organizational structure or status, Charter, Articles of Incorporation, Bylaws, Partnership Agreement, affiliations, officers, directors, members, owners, stockholders or location of books and records since the date of the application or the last Annual statement was filed with the Department?<i>(Note: Any provider transferring more than 10% of its stock or ownership to an unlicensed provider is barred from settling policies within this state until the Commissioner approves a new life settlement application whenever the provider is either organized within this state or conducting at least 5% of its business within the state.)</i></p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>(i) If there has been a change, has complete documentation been filed with the Department (i.e. amendments, biographical affidavits, fingerprint cards)?</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>(ii) If there has been a change and complete documentation was not provided to the Department, attach a complete documentation.</p>		
<p>b. Has any officer, director, member, stockholder, or employee of the provider been the subject of any administrative or judicial proceeding, had any license denied, suspended or revoked, been arrested, indicted, convicted, or pled nolo contendere to any criminal or civil action other than a minor traffic violation, or had a lien, judgment or foreclosure action filed against him or her since the date of application or the last Annual Statement was filed with the Department?</p> <p>If so, attach a detailed explanation sufficient to disclose all relevant details of the matter, to include its final disposition.</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>c. Does the provider have pending, or has the provider been involved in, any legal actions, civil suits, criminal proceedings, or had a license denied, suspended, or revoked by any government agency or regulatory body since the date of application or the last Annual Statement was filed with the Department?</p> <p>If so, attach a detailed explanation sufficient to disclose all relevant details of the matter, to include its final disposition.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>d. During the preceding year has the provider received any complaints from consumers alleging that the escrow or third party trustee did not disburse the life settlement proceeds within three (3) business days of receiving notification that the change in ownership or beneficial interest had been effected?</p> <p>If YES, attach a list of such complaints and describe what actions the provider took to correct the situation and prevent its recurrence. If the settlement funds are yet unpaid, include an explanation for the delay and anticipated payment date.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>8. DISCLOSURE INFORMATION</b></p>	
<p>a. Has the provider provided all disclosures required in California Insurance Code Section 10113.2(e) and Title 10, California Code of Regulations, section 2548.30, including disclosure of all commissions and fees paid in the life settlement transaction?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>9. FORM INFORMATION</b></p>	
<p>a. Has the provider filed with the Department a copy of all life settlement forms to be used in California?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>10. CONFIDENTIAL INFORMATION</b></p>	
<p>a. Was all medical or financial information solicited/obtained relative to the life settlement contract treated as confidential?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>11. EXAMINATION INFORMATION</b></p>	
<p>a. State what date the last examination on the company was made or is being made and by what insurance Commissioner. Date: _____ Insurance Commissioner _____</p>	
<p><b>12. ESCROW ACCOUNT INFORMATION</b></p>	
<p>a. Has the provider set up an escrow account wherein to deposit funds to pay its policy owners?</p> <p>Name the financial institution where the escrow account is located and the name of the escrow agent:</p> <p>Name of Financial Institution: _____</p> <p>Name of Escrow Agent: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No