



STATE OF CONNECTICUT

INSURANCE DEPARTMENT

P.O. Box 816, Hartford, CT 06142 - 0816

Life Settlement Provider Renewal Application

Life Settlement Provider: _____ Date Sent: _____

Contact for questions or future correspondence: _____

Address: _____

Phone #: _____ FAX#: _____

E-mail address: _____

Current License Expiration Date: _____

\$40 Fee, Check Made Payable to the Treasurer, State of Connecticut is attached

Failure to complete & return this form with your fee will result in non-renewal of your provider license. Please allow a minimum of 30 days to ensure your application will be renewed on time.

Attached is a copy of a certificate of good standing from the domiciliary state of this entity (if different) dated no more than fifteen (15) days before or after the date of this renewal filing.

Attached is the antifraud plan that includes the following:

- A description of the procedures for detecting and investigating possible fraudulent insurance acts.
- A description of the procedures for reporting fraudulent insurance acts.
- A description of the plan for antifraud education and training of its underwriters and other personnel.
- A written description or chart outlining the arrangement of the antifraud personnel responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

- Attached is the plan of operation if changed from prior year filing.
- Attached is written designation of an agent for service of process, or written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.
- Attached is the annual statement as of first day of March that includes, for any life policy acquired under a life settlement contract within five years of the policy's original issuance, (1) the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year and (2) a breakdown of the information by policy issue year, the names of the insurance companies whose policies have been settled, and the brokers involved. The information required is limited to those transaction where the insured is a Connecticut resident and must exclude individual transaction data that could be used to identify the owner or the insured.
- Attached are changes to the existing application on file with the Insurance Department for the above life settlement provider, along with the appropriate supporting documentation.
- Identity of Stockholders owning 10% or more of the shares.
- Has any member, director or officer ever been convicted of a crime or been found guilty of fraudulent or dishonest practices.
- Has any member, etc. ever been subject to administrative proceeding involving violations of insurance laws relating to life settlements.

A provider that willfully fails to file an annual statement as required in this section or willfully fails to reply not later than thirty days to a written inquiry by the Commissioner in connection therewith, shall, in addition to other penalties provided by this part, be subject upon due notice and opportunity to be heard to a penalty of up to two hundred and fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

CERTIFICATION OF ACCURACY

I certify on behalf of the Applicant, that the Applicant intends to act in good faith as a life settlement provider and to comply with all applicable Connecticut laws and with all applicable rules and orders of the Connecticut Commissioner of Insurance.

I further certify that neither the applicant, nor any partner, key manager, director, officer or majority stockholder of the applicant has been convicted of a felony.

Signature

Name (Printed)

Title

State of _____)

)ss:

County of _____)

Sworn before me this _____ day of _____, 20_____

_____, **Notary Public**

My Commission Expires: _____