GOLDEN OPPORTUNITY NETWORK®
CLIENT EVALUATION FORM

WHO IS THE INSURED ON THE POLICY?

FIRST | MIDDLE | LAST | GENDER Circle One: M F

HOME ADDRESS – APT #

CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMAIL ADDRESS

MARITAL STATUS | DATE OF BIRTH (mm/dd/yyyy) / /

Please be sure to return or upload a copy of the insured's driver license or government identification.

WHO IS THE OWNER OF THE INSURANCE POLICY?

IS THE OWNER TRUST OR CORPORATION? Circle One: YES NO

IF YES, PLEASE EXPLAIN _____

IS THE INSURED ON THE POLICY ALSO THE POLICY OWNER? Circle One: YES NO

IF YES, SKIP THE REST OF THIS SECTION

FIRST | MIDDLE | LAST | GENDER Circle One: M F

CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMAIL ADDRESS

MARITAL STATUS | DATE OF BIRTH (mm/dd/yyyy) / /

WHY ARE YOU CONSIDERING SELLING THIS POLICY? _____

Please be sure to return or upload a copy of the owner's driver license or government identification.

WHAT ARE THE POLICY SPECIFICS?

If you have multiple policies, please let us know.

NAME OF THE INSURANCE COMPANY | POLICY NUMBER

POLICY TYPE? Circle One: WHOLE LIFE UNIVERSAL LIFE TERM GROUP OTHER

DATE OF ISSUE (mm/dd/yyyy) / / | FACE VALUE $ | ANNUAL PREMIUMS $ | SURRENDER VALUE $ | LOAN VALUE $

BENEFICIARY NAME | RELATIONSHIP TO THE INSURED | DATE OF BIRTH (mm/dd/yyyy) / /

ARE THERE ANY RIDERS ON THE POLICY? Circle One: YES NO

IF YES, PLEASE EXPLAIN _____

ARE THERE ANY LIENS? Circle One: YES NO

IF YES, PLEASE EXPLAIN _____

159 Crocker Park Blvd., 4th Floor
Westlake, OH 44145

GOLDEN OPPORTUNITY NETWORK

Toll free: 888.944.5715 | p: 440-385-4400
app@goldenopportunitynetwork.com

WHO ARE THE INSURED'S PHYSICIANS?

PRIMARY PRACTICE NAME | DOCTOR NAME | SPECIALTY

MAILING ADDRESS

CITY | STATE | ZIP

OFFICE PHONE | EMAIL ADDRESS | WEBSITE

DATE OF FIRST VISIT (mm/dd/yyyy) / / | DATE OF MOST RECENT VISIT (mm/dd/yyyy) / /

ADDITIONAL COMMENTS: _____

SECONDARY PRACTICE NAME | DOCTOR NAME | SPECIALTY

MAILING ADDRESS

CITY | STATE | ZIP

OFFICE PHONE | EMAIL ADDRESS | WEBSITE

DATE OF FIRST VISIT (mm/dd/yyyy) / / | DATE OF MOST RECENT VISIT (mm/dd/yyyy) / /

ADDITIONAL COMMENTS: _____

WHAT IS THE HEALTH AND MEDICAL HISTORY?

DESCRIBE THE INSURED'S CURRENT HEALTH CONDITION AS COMPARED TO OTHER INDIVIDUALS HIS/HER AGE:

Circle One: Excellent Good Poor Declining

PLEASE LIST ANY MEDICAL CONDITIONS: _____

The information provided will remain confidential and will not share this information with any outside party without your expressed authority.

By signing below, I hereby represent that the information provided is true and correct, to the best of my knowledge:

SIGNATURE OF POLICY OWNER: _____

SIGNATURE OF INSURED: _____

We will need to verify the information you provide in order to better evaluate the cash settlement potential of your life insurance policy. Please sign the "AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION & POLICY INFORMATION" document and have your signature witnessed. You may be required to participate in a telephone conference call with your insurance company or doctor's office in order to help us expedite our evaluation.

AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION AND INSURANCE POLICY INFORMATION

The undersigned hereby authorizes any physician, medical personnel, clinic, hospital, medical center, medical bureau, insurance company; and/or any other health care provider holding protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Protected Health Information") regarding the person(s) identified below as the Applicant/Insured, to disclose and/or release all Protected Health Information concerning or related to the medical and/or health condition of the Applicant/Insured to BCI Interactive, d/b/a Golden Opportunity Network® ("Company") and the employees, agents, representatives, successors, assigns, and designees of the Company (each, a "Recipient"), for the purpose of evaluating the health condition on the Applicant.

The undersigned further authorizes any insurance company providing life insurance coverage on the life of the Insured to furnish to the Company any and all information and/or documents which the Company may request in connection with such life insurance coverage, without limitation.

This authorization shall remain valid for the longer of (a) twenty-four (24) months following the date below or (b) the maximum period of time permitted under federal law and the laws of the state of residency with respect to whom use is sought, respectively.

This authorization is voluntary, and the undersigned (or an authorized personal representative, if acting on behalf of the Insured) can refuse to sign this authorization. Treatment, payment, enrollment, or eligibility for health benefits may not be conditioned by the health care providers of the Insured on the signing of an authorization, except as otherwise permitted by law. Any information, including but not limited to Protected Health Information, used or disclosed pursuant to this authorization may be subject to re-disclosure by the Company or by a Recipient and may no longer be protected by federal and/or state privacy and confidentiality rules.

The undersigned Insured may revoke this authorization in writing if revocation is delivered to the Company via first-class certified postage-prepaid mail, return receipt requested. Any revocation of this authorization shall not apply to the extent that the Company or any Recipient previously has relied upon this authorization.

This form may be signed in any number of counterparts, all of which together shall constitute one and the same original form. A photocopy or facsimile of this signed authorization is a valid representation of the original and shall be treated, and may be relied upon, as an original.

By signing below, each undersigned acknowledges that this authorization is written in plain English and will retain a copy of this signed authorization.

APPLICANT/INSURED INFORMATION:

Applicant/Insured's Signature: _____ Date: mm/dd/yyyy ____/____/____

Print Name: _____

SS#: ____-____-____ DOB: mm/dd/yyyy ____/____/____

Witness Signature: _____

Print Name: _____

POLICYOWNER INFORMATION (ONLY REQUIRED IF THE APPLICANT IS NOT THE POLICY OWNER):

Applicant/Insured's Signature: _____ Date: mm/dd/yyyy ____/____/____

Print Name: _____

SS#: ____-____-____ DOB: mm/dd/yyyy ____/____/____

Witness Signature: _____

Print Name: _____