**Section 5701.EXHIBIT H Verification of Coverage for Life Insurance Policies**

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SUBMITTED TO: | | |  | | | | | | | NAIC # | | |  |
|  | | | | Name of Insurance Company | | | | |  | | |  | |
|  | | | | | | | | | | | | | |
| POLICY NUMBER: | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | |
| SUBMITTED FROM: | | | | |  | | | | | | | | |
|  | | | | | Name of Viatical Settlement Broker/Provider | | | | | | | | |
|  | | | | | | | | | | | | | |
| ADDRESS: |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| TELEPHONE NUMBER: | | | | | |  | | | | | | | |
|  | | | | | | |  | | | | | | |
| CONTACT: | |  | | | | | | TITLE: | | |  | | |

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE, PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

|  |  |  |
| --- | --- | --- |
|  | This column to be completed by Viatical Settlement Broker/Provider | This column to be used by Insurance Company |
| Owner's name | \* |  |
| Address | \* |  |
| City, state, ZIP code | \* |  |
| Tax ID or social security number | \* |  |
| Insured's name | \* |  |
| Insured's date of birth | \* |  |
| Second insured's name (if applicable) | \* |  |
| Second insured's date of birth (if applicable) | \* |  |

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  |  |
| Signature of policy owner |  | | Date signed |

Form VOC

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| IS THE POLICY IN FORCE? |  | YES |  | NO |

*IF NO, SIGN AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \* |  | TERM |  | WHOLE LIFE |  | UNIVERSAL LIFE |  | VARIABLE LIFE |

If a question is not applicable to the type of policy, write N/A in the column.

|  |  |  |
| --- | --- | --- |
|  | This column to be completed by Viatical Settlement Broker/Provider | This column to be used by Insurance Company |
| Original issue date | \* |  |
| Maturity date of policy |  |  |
| State of issue | \* |  |
| Does the policy have an irrevocable beneficiary? | \* |  |
| Is the policy currently assigned? | \* |  |
| Was the policy ever converted or reinstated? |  |  |
| Is the policy in the contestability period? | \* |  |
| Is the policy in the suicide period? | \* |  |
| Please list all riders and indicate if any are in the contestable or suicide period. | \* |  |

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POLICY VALUES

|  |  |  |
| --- | --- | --- |
|  | This column to be completed by Viatical Settlement Broker/Provider | This column to be used by Insurance Company |
| Policy values as of (insert date) |  |  |
| Current face amount of policy | \* |  |
| Amount of accumulated dividends |  |  |
| Current face amount of riders |  |  |
| Amount of any outstanding loans | \* |  |
| Amount of outstanding interest on policy loans |  |  |
| Current net death benefit | \* |  |
| Current account value | \* |  |
| Current cash surrender value | \* |  |
| Is policy participating? | \* |  |
| If yes, what is the current dividend option? |  |  |

PREMIUM INFORMATION

|  |  |  |
| --- | --- | --- |
|  | This column to be completed by Viatical Settlement Broker/Provider | This column to be used by Insurance Company |
| Current payment mode | \* |  |
| Current modal premium | \* |  |
| Date last premium paid | \* |  |
| Date next premium due | \* |  |
| Current monthly cost of insurance as of (insert date) |  |  |
| Date of last cost of insurance deduction |  |  |

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature |  | Printed Named |

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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TO BE COMPLETED BY INSURANCE COMPANY | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| The information provided by verification by the insurance company is correct and accurate to the best | | | | | | | | | | | | | | | | | | | |
| of my knowledge as of | | | | | | | | | | | (date) | . | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Insurance company: | | | | | | | | | |  | | NAIC # | | |  | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
| Printed name: | | |  | | | | | | | | | Title: | |  | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
| Telephone number: | | | | | | | |  | | | | Fax number: | | | | |  |  | |
|  | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | |
| *Please provide information about where the forms listed below should be submitted for processing.* | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | Title: |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| Company name: | | | | | |  | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| Mailing address: | | | | | |  | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| City, state, Zip: | | | |  | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| Overnight address: | | | | | | |  | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| City, state, Zip: | | | | |  | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| Telephone number: | | | | | | | | |  | | | Fax number: | | | |  | | |  |
|  | | |  | | | |

FORMS REQUEST

Please provide the forms checked below:

○ Absolute Assignment/Change of Ownership/Viatical Assignment

○ Change of Beneficiary

○ Release of Irrevocable Beneficiary (if applicable)

○ Waiver of Premium Claim Form

○ Disability Waiver of Premium Approval Letter

○ Release of Assignment

○ Change of Death Benefit Option Form (if UL)

○ Allocation Change Form (if Variable)

○ Annual Report

○ Current In Force Illustration

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(Source: Added at 39 Ill. Reg. 16161, effective December 3, 2015)