Catalyst Viaticals

HIPAA AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

NAME OF INSURED	DATE OF BIRTH

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager or other healthcare provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, medications prescribed and any other protected health information concerning me, including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted disease, treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes (the "Medical information") to Catalyst V Opportunistic SPV Fund I and any of its successors, assigns or authorized representatives ("Catalyst").

By my signature below, I acknowledge that any agreements I have made to restrict my Medical Information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, pharmacy benefit manager or other healthcare provider to release and disclose my entire medical records without restriction.

This Medical Information is to be disclosed under this Authorization so that Catalyst may: 1) underwrite my application for life settlement eligibility, risk rating, policy and or/annuity issuance and enrollment determinations; 2) obtain reinsurance; and

3) conduct other legally permissible activities that relate to any product I have or have applied for with Catalyst. I further consent that the Medical Information may be disclosed to a licensed life settlement provider, licensed life settlement broker and any life insurance company issuing a life insurance policy covering my life.

This release is valid for the lesser of 24 months or the closing of the request following the date of my signature below, and a copy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Catalyst at the following address: 3020 Wilshire Blvd, Suite H, Santa Monica, CA 90403.

I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me.

I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by Catalyst. except as authorized by me or as permitted by law.

I understand that My Providers may not refuse to provide treatment or payment for healthcare services if I refuse to sign this authorization.

I further understand that if I refuse to sign this authorization to release my complete medical records, Catalyst may not be able to process my application.

I understand that any authorized representative or I will receive a copy of this authorization upon request. This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

SIGNATURE OF PROPOSED INSURED OR PERSONAL REPRESENTATIVE	DATE
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY OR RELATIONSHIP TO PATIENT	