COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

To: **Viatical Settlement Providers**

From: **Steve Matthews, Chief Financial Examiner**

Re: **Annual Statement Filing Information**

Date: **January 1, 2016**

Attached is a form on which to file your company's 2015 Annual Statement with Montana Insurance Department. Under the provisions of Montana Insurance Code, the fee of $1,900 for renewal of a viatical settlement provider certificate of authority is due with the filing of the annual statement on or before March 1, 2016 (postmark accepted). If problems meeting the filing deadline are anticipated, written requests for an extension of the deadline will always be considered.

It should be noted that Montana considers the viatical settlement provider annual statement a public document. Audited financial statements are considered confidential.

I encourage you to contact Tim Morris of my office with any questions and/or concerns you may have. Additional if you see a need for additional clarifications, please let us know.

Thank you for your time and efforts.

Phone 1-800-332-6148 / (406) 444-2040 / Fax: (406) 444-3497
Securities Fax: (406) 444-5558 / PHS Fax: (406) 444-1980 / Legal Fax: (406) 444-3499
840 Helena Avenue, Helena, MT 59601 Website: wwwcsi.mt.gov E-mail: csi@mt.gov

VIATICAL SETTLEMENT PROVIDER ANNUAL REPORT

OF

_____

_____

(NAME OF VIATICAL SETTLEMENT PROVIDER)

TO THE

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE

STATE AUDITOR'S OFFICE

OF THE STATE OF MONTANA

840 HELENA AVENUE

HELENA, MT 59601

FOR THE YEAR ENDED DECEMBER 31, _____

01/16

** GENERAL INSTRUCTIONS **

1. This report and the required $1,900 in fees must be received by the Department annually by March 1.

2. Type or print all responses in ink. Annual reports must be filed on official Department forms or other forms determined by the Department to be substantially identical in all material respects to official Department forms.

3. Respond fully to each item. Reports containing blank lines or unanswered questions may be deemed incomplete. Reply with None, Not Applicable, N/A, or 0, as applicable.

4. Attach copies of application forms, contracts and other forms required by 33-1-501 and 33-20-1308, MCA that have not yet been approved by the commissioner.

5. Attach copies of information brochures, advertising and other solicitation materials that a provider or broker uses to market Viatical settlements to viators or prospective viators in this state that have not yet been approved by the commissioner.

6. Attach and clearly identify and cross reference any supporting documentation or schedules which may be necessary to fully respond to particular report items.

7. Individual viators shall be identified by a settlement number in this report.

8. On or before June 1 of each calendar year, a viatical settlement provider licensed in this state shall submit an annual audited financial statement, if such statements are regularly prepared by or for the viatical settlement provider in the ordinary course of business, or such other financial information as the commissioner shall require pursuant to 6.6.8510(2) ARM.

7. Name of person completing this report: _____ Date:_____

Telephone Number: _____ Fax Number:_____

IT IS THE RESPONSIBILITY OF EACH LICENSED PROVIDER TO COMPLY WITH APPLICABLE STATUTES AND REGULATIONS AT ALL TIMES. SHOULD ANY QUESTIONS OF COMPLIANCE EXIST, PLEASE CONTACT THE EXAMINATIONS BUREAU IN THE MONTANA INSURANCE DEPARTMENT.

ATTESTATION INSTRUCTIONS

ATTESTATIONS SUBMITTED MUST BE ORIGINALS. COPIES ARE NOT ACCEPTABLE.

This report must be attested to by the following, based upon organizational structure of the viatical settlement provider:

1. If the viatical settlement provider is a corporation, the report must be attested by at least two principal officers of the viatical settlement provider;

2. If the viatical settlement provider is a partnership, the report must be attested by two partners; or

3. If the viatical settlement provider is not a corporation or a partnership, by the provider's owner and manager.

Annual Report Attestation

Name of Viatical Settlement Provider:
_____

Type Of Business Organization:
_____

MAILING ADDRESS

Street or PO Box:
_____

City of: _____ State: _____ Zip:_____

Phone #: _____ Fax #: _____ Web Site: _____

As an individual responsible for conducting the affairs of the above named viatical settlement provider licensed to transact business in the State of Montana, I am familiar with the laws of Montana relating to viatical settlement providers and do hereby verify pursuant to Section 33-20-1309, MCA, that the information reported herein is a true and correct reporting of the requested information.

_____ _____
(Typed Name) (Typed Name)

_____ _____
(Signature) (Date) (Signature)
(Date)

_____ _____
(Title) (Title)

Sworn to and subscribed before me

This day of _____, 20_____

NOTARY PUBLIC for the state of_____

Residing at_____

My commission expires_____

(SEAL)

Sworn to and subscribed before me

This day of _____, 20_____

NOTARY PUBLIC for the state of_____

Residing at_____

My commission expires_____

(SEAL)

INSTRUCTIONS

ATTESTATIONS SUBMITTED MUST BE ORIGINALS. COPIES ARE NOT ACCEPTABLE.

This report must be attested to by the following, based upon organizational structure of the viatical settlement provider:

1. If the viatical settlement provider is a corporation, the report must be attested by at least two principal officers of the viatical settlement provider;

2. If the viatical settlement provider is a partnership, the report must be attested by two partners; or

3. If the viatical settlement provider is not a corporation or a partnership, by the provider's owner and manager.

Viatical Settlement Provider Attestation – Securities Compliance Requirement

Name of Viatical Settlement Provider:
_____

Type Of Business Organization:
_____

MAILING ADDRESS

Street or PO Box:
_____

City of: _____ State: _____ Zip:_____

Phone #: _____ Fax #: _____ Web Site: _____

As an individual responsible for conducting the affairs of the above named Viatical settlement provider applying to transact business in the State of Montana, I am familiar with the laws of Montana relating to securities regulation and do hereby state that the Viatical settlement provider will comply with the Montana Securities Act.

_____ _____
(Typed Name) (Typed Name)

_____ _____
(Signature) (Date) (Signature)
(Date)

_____ _____
(Title) (Title)

Sworn to and subscribed before me Sworn to and subscribed before me

This day of _____, 20_____ This day of _____, 20_____

NOTARY PUBLIC for the state of_____ NOTARY PUBLIC for the state of_____

Residing at_____ Residing at_____

My commission expires_____ My commission expires_____

(SEAL) (SEAL)

Annual Report for 20__ for_____

Assets	**Current Year**	**Prior Year**
1. Cash on Hand and in Company Office		
a. Cash in Company Office	_____	_____
b. Cash on Deposit	_____	_____
2. Certificates of Deposit	_____	_____
3. Investments		
a. Bonds	_____	_____
b. Common Stock	_____	_____
c. Preferred Stock	_____	_____
d. Short Term Investments	_____	_____
4. Purchased Policies	_____	_____
5. Matured Polices Receivable	_____	_____
6. Interest Receivable on Matured Policies	_____	_____
7. Property and Equipment	_____	_____
8. Investment Income Due and Accrued	_____	_____
9. Other Assets		
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
10. Total Assets	_____	_____
Liabilities and Shareholders Equity		
Liabilities		
11. Bank Loan/Long Term Loan	_____	_____
12. Policy Premiums Due	_____	_____
13. Taxes, Licenses & Fees Due & Accrued	_____	_____
14. Liability for Benefits for Employees	_____	_____
15. Payable to Parent, Subsidiaries and Affiliates	_____	_____
16. Dividends Payable	_____	_____
17. Other Payables (Short Term Debt)	_____	_____
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
18. Total Liabilities	_____	_____
Shareholder Equity		
19. Common Capital Stock	_____	_____
20. Preferred Capital Stock	_____	_____
21. Retained Earnings	_____	_____
22. Total Shareholder Equity	_____	_____
23. Total Liabilities and Shareholder Equity	_____	_____

Annual Report for 20__ for_____

Report of Income	**Current Year**	**Prior Year**
1. Proceeds Received from Matured Polices	_____	_____
2. Fees Received from Contract Holders	_____	_____
3. Investment Income	_____	_____
4. Other Income	_____	_____
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
5. Total Income	_____	_____
6. General and Administrative Expenses	_____	_____
7. Interest Expense	_____	_____
8. Other Expenses	_____	_____
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
9. Total Expenses	_____	_____
10. Net Income before Federal Income Tax	_____	_____
11. Federal Income Tax	_____	_____
12. Net Income after Federal Income Tax	_____	_____

Report of Changes in Shareholder Equity		
13. Balance of Shareholder Equity at December 31, PY	_____	_____
14. Net Income	_____	_____
15. Capital Contributions/(Distributions)	_____	_____
16. Dividends Paid	_____	_____
17. Other Changes		
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____
18. Balance of Shareholder Equity at December 31, CY	_____	_____

Annual Report for 20__ for_____

Cash Flow	**Current Year**	**Prior Year**
1. Proceeds from Matured Polices	_____	_____
2. Fees from contract holders	_____	_____
3. Investment Income	_____	_____
4. Interest Income	_____	_____
5. Other Income	_____	_____
6. Total (Items 1 thru 5)	_____	_____
7. Payment made to viators for Purchased Policies	_____	_____
8. Federal Income Taxes paid	_____	_____
9. Premiums paid	_____	_____
10. Policy Loans paid	_____	_____
11. Other Expenses paid	_____	_____
12. Total (Items 7 thru 11)	_____	_____
13. Net Cash from Operations (Item 6 minus 12)	_____	_____
14. Proceeds from sale of Investments	_____	_____
15. Proceeds from sale of fixed assets	_____	_____
16. Cost of investment acquired	_____	_____
17. Purchase of fixed assets	_____	_____
18. Net Cash from Investments (Items 14 &15 minus 16 &17)	_____	_____
19. Other Cash provided:	_____	_____
a. Proceeds from issuance of stock	_____	_____
b. Contributions	_____	_____
c. Proceeds from line of credit	_____	_____
d. Advances from related parties	_____	_____
e. Other sources	_____	_____
f. Total Other Cash Provided	_____	_____
20. Funds paid to related parties	_____	_____
21. Funds paid on long-term debt/and or credit line	_____	_____
22. Other payment made	_____	_____
23. Net Cash from Financing (Item 19f minus (20, 21 & 22)	_____	_____
24. Other Cash Applications	_____	_____
a. Dividends paid to stockholders	_____	_____
b. Other applications	_____	_____
25. Total Other Cash Applied (Item 24a plus 24b)	_____	_____
26. Net Change in Cash (Item 13 plus 18 plus 23 minus 25)	_____	_____

Reconciliation

27. Cash and Certificate of Deposits		
a. Beginning of the year	_____	_____
b. Plus / Minus Item 26	_____	_____
c. End of Year	_____	_____

Annual Report for 20__ for_____

Exhibit 1
List of Montana Viaticated Polices Miscellaneous Information

Settlement Number	Issuer of Policy	Policy Number	Policy Issue Date *	Is This Policy a Premium Financed Policy (Yes or No)	Date Policy Originally Acquired From Viator	Has the Person Become Terminally Ill Since the Policy Originally Issued (Y or N)	Is the Policyholder Chronically Ill (Y or N)	Has The Viatical Settlement Provider Given Copies Of Certification And Independent Evidence To The Insurer When A Request Was Made To The Insurer For Verification Of Coverage (Y Or N)	Did The Viatical Settlement Provider Pay A Finder's Fee, Commission, Or Other Compensation To The Attending Physician, Attorney, Or Accountant Or Any Other Person Who Provides Medical, Legal, Financial Planning Services, Or Agent To The Policyholder (Y Or N)

*** A person may not enter into a Viatical Settlement Contract within a 2-year period from the date of issuance unless the criteria of 33-20-1313, MCA has been met.**

SCHEDULE A - LIST OF OFFICERS/DIRECTORS AND KEY PERSONNEL

List the name, title, percentage of ownership interest, business address and residence address of each individual who is responsible for the conduct of the providers affairs or has the ability to exercise significant control over the provider, including but not limited to officers, directors, trustees, partners, shareholders holding a 10 percent or greater interest in the provider, and key personnel. Place an asterisk next to the name of any individual not reported on the most recent report or application (whichever occurred last). Attach additional sheets as necessary.

Name	Title	Percentage of Ownership (if any)	Business Address	Residence Address

SCHEDULE B - AGED SCHEDULE OF UNSETTLED VIATICAL CONTRACTS FOR MONTANA RESIDENTS

Provide, as of December 31, an aging analysis for all outstanding Viatical settlement contracts that have been executed by viators.

DAYS SINCE EXECUTION BY VIATOR	DOLLAR VALUE
Executed less than 30 Days	$_____
Executed 30 to 59 days	$_____
Executed 60 to 89 days	$_____
Executed 90 to 119 days	$_____
Executed 120 to 149 days	$_____
Executed 150 to 179 days	$_____
Executed 180 or more days	$_____
TOTAL	$_____

SCHEDULE C - SETTLEMENTS PAID FOR MONTANA RESIDENTS

(Most recent five years, beginning with this reporting year)

YEAR	TOTAL NUMBER OF POLICIES PURCHASED (Quantity)	TOTAL SETTLEMENTS PAID FOR POLICIES PURCHASED (DOLLARS)	TOTAL FACE VALUE OF POLICIES PURCHASED (DOLLARS)
20 __	_____	$_____	$ _____
20 __	_____	$ _____	$_____
20 __	_____	$_____	$ _____
20 __	_____	$ _____	$ _____
20 __	_____	$ _____	$ _____

Interrogatories

1. Has there been any change in the provider's name, organizational structure, articles of incorporation, by- laws, partnership agreement, officers, directors, members, owners, stockholders or location of books and records since the latter of the date of application or the last Annual Report was filed with this Department? ❑ Yes ❑ No
If there has been a change, has complete documentation been filed with the Department (i.e., amendments, biographical affidavits) ❑ Yes ❑ No ❑ N/A
If there has been a change and complete documentation was not provided to the Department, attach complete documentation.

2. 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 latter of the date of application or the last Annual Report was filed with this Department? ❑ Yes ❑ No
If so, attach a detailed explanation sufficient to disclose all relevant details of the matter, to include its final disposition.

3. Has the provider been involved in any legal actions, civil suits, criminal or administrative proceedings, or had a license denied, suspended or revoked by any government agency or regulatory body since the latter of the date of application or the last Annual Report was filed with this Department? ❑ Yes ❑ No
If so, attach a detailed explanation sufficient to disclose all relevant details of the matter, to include its final disposition.

4. During the reporting year has the provider received any complaints from viators alleging that the escrow agent or third party trustee did not disburse the Viatical settlement within three business days of receiving notification that the change in ownership or beneficial interest had been effected? ❑ Yes ❑ No
If yes, attach a list of such complaints, including the name of the viator, policy face amount, settlement amount, contract date, date of insurer notification, and date funds were released to the viator. 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.

5. Did the provider engage in the re-sale to an institution or individual, during the year covered by this report, any Montana viaticated life insurance policies? ❑ Yes ❑ No
If yes, please provide proof of viators written permission.

INTERROGATORIES
(continued)

6. Funds used to purchase Montana life insurance policies are provided by:
   6.1) Owners, partners or other officers ❑ Yes ❑ No
   6.2) Affiliated companies ❑ Yes ❑ No
   6.3) Financial institutions ❑ Yes ☐ No
   6.4) Private investors ❑ Yes ❑ No
   6.5) Others, please describe _____

7. State as of what date the latest examination of the provider was made or is being made._____ By what department or departments?_____

8. Is the provider submitting its annual audited financial statements or another form of financial statements? ❑ Yes ❑ No

9. Regarding Viatical settlements executed in Montana during the reporting year:
   9.1) Number executed during the year? _____
   9.2) Total amount of settlements paid during the year? $_____
   9.3) Total amount payable for outstanding settlements? $_____

10. Did the provider comply during the reporting year with the minimum percentages that must be paid (per 6.6.8507 ARM) on the face value of the viaticated life insurance policies? ❑ Yes ❑ No ❑ N/A

11. Did the provider change the trustee, escrow agent or approved bank handling the proceeds of Viatical settlements during the report year? ❑ Yes ❑ No

12. Did the provider engage in life settlement business (where the viator's life expectancy is greater than 24 months) in Montana in the current year? ❑ Yes ❑ No

Supporting Documents

1. Please complete and submit the annual report as of the close of business on December 31:

2. Provide a letter of Certification of Securities Compliance as defined in 6.6.8509 ARM.

3. Provide a copy of an executed surety bond in the amount of $50,000 payable to the State of Montana, or.

4. Provide a copy of an errors and omissions policy in an amount commensurate with the provider's exposure.

5. Provide a completed copy of VSP 001; VSP 002; VSP 003; and VSPB 001.

6. On or before June 1 of each calendar year, a viatical settlement provider licensed in this state shall submit an annual audited financial statement, if such statements are regularly prepared by or for the viatical settlement provider in the ordinary course of business, or such other financial information as the commissioner shall require pursuant to 6.6.8510(2) ARM.

Viatical Settlement Provider Report

_____

Viatical Settlement Provider's Name

All States and Territories

Calendar year **200__**

	1	2	3	4	5	6	7	8	
States	Are you doing business in this state? (Y/N)	Total number of policies reviewed for consideration	Total number of policies where an offer was made	Total number of policies where an offer was not made	Total number of policies purchased	Aggregate total net death benefit	Aggregate amount paid to viators	Secondary market transactions	
								pur	sold
Alabama									
Alaska									
Arizona									
Arkansas									
California									
Colorado									
Connecticut									
Delaware									
Dist. of Columbia									
Florida									
Georgia									
Hawaii									
Idaho									
Illinois									
Indiana									
Iowa									
Kansas									
Kentucky									
Louisiana									
Maine									
Maryland									
Massachusetts									
Michigan									
Minnesota									
Mississippi									
Missouri									
Montana									
Nebraska									
Nevada									
New Hampshire									

	1	2	3	4	5	6	7	8	
States	Are you doing business in this state? (Y/N)	Total number of policies reviewed for consideration	Total number of policies where an offer was made	Total number of policies where an offer was not made	Total number of policies purchased	Aggregate total net death benefit	Aggregate amount paid to viators	Secondary market transactions	
								pur	Sold
New Jersey									
New Mexico									
New York									
North Carolina									
North Dakota									
Ohio									
Oklahoma									
Oregon									
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Vermont									
Virginia									
Washington									
West Virginia									
Wisconsin									
Wyoming									
American Samoa									
Guam									
Puerto Rico									
U.S Virgin Islands									
Canada									
TOTALS									

VSP 001

Initials of preparer: _____

Viatical Settlement Provider Report—All States and Territories Instructions

***NOTE*: This form must be accompanied by Viatical Settlement Provider/Broker Certification Form.**

1. Indicate (Y or N); have you done business in this state during the calendar year being reported.
2. For that state or territory, indicate the total number of policies reviewed for consideration for that state or territory.
3. For that state or territory, indicate the total number of policies where an offer was made.
4. For that state or territory, indicate the total number of policies where an offer was refused.
5. For that state or territory, indicate the total number of policies purchased.
6. List the total aggregate net death benefit of the policies viaticated in that state or territory.
7. List the total aggregate amount paid to viators in that state or territory.
8. List the total number of policies purchased and/or sold in the secondary market for that state or territory.

Initials of preparer: _____

_____

Viatical Settlement Provider's Name

Viatical Settlement Provider Report

Calendar year _____

Montana Transactions Only

200___

1	2	3	4	5	6	7	8	9	10	11
Viatical settlement provider settlement number	Contract date purchased	Total net death benefit ($)	Age of insured at time of contract	Life expectancy at time of contract.	Net amount paid to viator ($)	Policy type: I or G	Funding: F, P, I, T or RPT	Source of policy: B, D, SM, P or O	Commission amount ($)	Name of source of policy

VSP 002

Initials of preparer: _____

Viatical Settlement Provider Report Montana Insured's Only Instructions

***NOTE*: This form must be accompanied by Viatical Settlement Provider/Broker Certification Form**

1. List the settlement number, case number or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date the viatical settlement contract was purchased by the provider during the current calendar year, whether or not the insured is still alive at the end of the calendar year.

3. List the net amount (in dollars) being viaticated.

4. List the age (in years) of the person insured by the policy being viaticated, at the time of the viatical settlement contract.

5. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract.

6. List the net amount (in dollars) paid to the viator.

7. Identify whether the policy was an individual policy (I) or a group policy (G).

8. List the type of funding for the transaction: "F" for a licensed financial institution (policies collateralized), "P" for private (purchaser) funding, "I" for internal funding, "T" for trust, and "RPT" for related provider trust.

9. Indicate the purchase source of the policy. Use "B" for viatical settlement broker, "D" for direct from the viator, "I" for insurance agent/producer, "SM" for a secondary market or viatical settlement provider, "P" for private (purchaser) funding or "O" for other.

10. List the amount of commissions (in dollars) paid to viator source involved in the transaction whether that be a viatical settlement broker, an insurance producer or other licensed entity authorized to be viator source.

11. List the name of the source of the viatical settlement transaction. If it is a broker, producer or other licensee, name that person; if it is direct, from a relative, from the corporation of the insured or any other entity that could possibly reveal the insured, designate by writing "Direct," "Relative," "Corporation," or other nondesignating word.

 Initials of preparer: _____

Individual Mortality Report

_____

Viatical Settlement Provider's Name

Calendar year

Montana Insured's Only

200___

1	2	3	4	5	6	7	8	9	10
Viatical settlement provider's settlement number	Contract date	Age of insured at time of contract	Life expectancy at time of contract	Net amount paid to viator	Date of death	Total premiums paid to maintain policy	Death benefit collected	Number of months between date of contract and date of death	Number of months between life expectancy at contract date and date of death (+ / -)

VSP 003

Completed by Viatical Settlement Providers

Initials of preparer: _____

Individual Mortality Report— Montana Insured's Only Instructions

<u>NOTE</u>: This form must be accompanied by the Viatical Settlement Provider/Broker Certification Form.

1. List the settlement number, case number, or unique identifying number used to identify the specific viatical settlement transaction.

2. List the date of the viatical settlement contract.

3. List the age of the insured at the time of the contract.

4. List the life expectancy (in months) of the insured individual at the time of the viatical settlement contract. For first to die policies, use the shortest life expectancy of the two lives. For second to die policies, use the longest life expectancy of the two lives.

5. List the "Net" amount paid to the viator.

6. Indicate the insured's date of death. For first to die policies, use the date of the first insured's death. For second to die policies, use the date of the last insured's death.

7. List the total amount of premiums (in dollars) required to be paid to the insurer to maintain the policy from the date of viatication to the date of death.

8. List the total death benefit collected from the insurer.

9. List the number of months between the date of contract and the insured's date of death.

10. List the number of months between the life expectancy of the insured at the time of contract and the insured's date of death. This should be noted as a plus (+) figure if the insured died after the estimated life expectancy or a minus (-) if the insured died prior to the estimated life expectancy.

 Initials of preparer:_____

Viatical Settlement Provider Certification Form

<u>This section should be completed by viatical settlement providers.</u>

Please check all forms submitted:

- ☐ Viatical Settlement Provider Reporting Form - All States and Territories (VSP 001)
- ☐ Viatical Settlement Provider Reporting Form – Montana Insured's Only (VSP 002)
- ☐ Individual Mortality Report - Montana Insured's Only (VSP 003)

I hereby certify that the information contained in the reports indicated above is true and accurate. I acknowledge that providing false and misleading information in the reports, or failing to divulge a fact material thereto, is sufficient grounds for administrative action by the commissioner and potentially, applicable criminal penalties

_____ Date: ____/____/____
Signature of individual that prepared reports

_____
Print or type name

_____ Date: ____/____/____
Signature of Authorized Representative

_____
Print or type name

VSPB 001