



Florida Office of Insurance Regulation

Notice of Intent to Use a Related Provider Trust

Provider/Applicant Name: _____

Address: _____

City, State Zip: _____

Phone Number: _____ Fax Number: _____

☐ Licensed Viatical Settlement Provider # _____ ☐ Viatical Settlement Provider Applicant

The Provider or Applicant named above hereby gives notice to the Office of Insurance Regulation of its intent to use a Related Provider Trust, as defined in Section 626.9911(8), Florida Statutes.

The Provider or Applicant does hereby represent that the Related Provider Trust named below, established by the Provider or Applicant pursuant to the attached Trust Agreement, is being or has been established as a Related Provider Trust as defined by Section 626.9911(8), F.S., for the sole purpose of entering into or owning viatical settlement contracts. The Related Provider Trust is subject to all provisions of the Viatical Settlement Act that apply to viatical settlement providers except Section 626.9912, F.S., and shall be the only Related Provider Trust established by the Provider or Applicant.

The Provider or Applicant further represents that it understands it is liable and responsible for the performance of all obligations of the Related Provider Trust established by it and is also responsible for compliance by the Related Provider Trust with all provisions of the Viatical Settlement Act. Further, the Provider or Applicant acknowledges that it accepts responsibility for any violation of the Act by the Related Provider Trust as if it is a violation of the Act by the Provider or Applicant.

Related Provider Trust Name: _____

Trustee Name: _____

Trustee Contact: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

In Witness Whereof, we, the President or Chief Executive Officer and Secretary of the Provider or Applicant, being duly authorized by the Board of Directors or governing body of said entity to execute this document, have hereunto set our hands and affixed the seal of said entity on this the _____ day of _____, 20____, A.D.

President or CEO's Signature

Secretary's Signature

President or CEO Name (Typed or Printed)

Secretary Name (Typed or Printed)

SEAL

Signatures must be validated by the attachment of a resolution of the Board of Directors or Governing body authorizing the establishment of a Related Provider Trust and Execution of this document.