Advisory Services

Terms and Conditions

SENIOR ADVISORS PLUS, LLC

This agreement ("Agreement") comprises three sections: SERVICES PROVIDED BY SENIOR ADVISORS PLUS, LLC; CLIENT'S CONSENT TO DISCLOSURE AND USE OF PROTECTED DATA; and AUTHORIZATION FOR RELEASE AND USE OF PROTECTED HEALTH INFORMATION.

SERVICES PROVIDED BY SENIOR ADVISORS PLUS, LLC

Senior Advisors Plus, LLC ("Senior Advisors Plus" or "SAP") assists clients in researching senior care and related senior services. SAP offers two services, Referral and Advisory. Under SAP's Referral Service, SAP refers the consumer ("Consumer" or "Consumers") to providers that will pay SAP for its referral. Under SAP's Advisory Service, the Consumer pays SAP a fee and SAP helps the consumer create a senior care strategy and then provides assistance with implementing the plan, which may include referring them to senior care providers. SAP is not limited to who it can refer a Consumer to when the Consumer employs its Advisory Service. Under SAP's Referral Service and Advisory Service, SAP assesses its clients' needs, evaluates options to meet those needs, and provides them with a list of referrals. Ultimately, clients choose the care and services they want. **This agreement is for those Consumers that want to use SAP's Advisory Services ("Services")**. The Services under this agreement that SAP may provide include:

a. Collect information, including personal, contact, financial, and health that we will use to determine your:
    i. Preferred geographic location
    ii. Level of needed care
    iii. Ability to afford a provider or servicer
    iv. Lifestyle preferences
b. Estimate affordability of senior care and services by making assumptions about your wealth, health care needs, service needs, cost of services, cost of health care, discount rates, subsidies, taxes, length of care, services, and benefits.
c. If appropriate, identify alternative funding sources, recommend monetizing assets, or introduce you to SAP's industry team that assists with subsidy applications, insurance claims, VA benefits applications, Medicare claims, Medicaid claims, and obtaining government waivers.
d. With your permission, send facilities and servicers the output of our affordability assessment of you.
e. Advise you of the most suitable senior care facilities or services from a list of prescreened providers.
f. For the communities that you would like to visit, schedule tours and then provide transportation. SAP will provide transportation up to two communities within 35 miles of Washington, D.C.
g. Attempt to negotiate on the sponsor's behalf a better, lower out-of-pocket cost that the provider or servicer charges.
h. If needed, introduce you to our industry team who may help you with your transition and discount their services

CONFIDENTIALITY AND FEEDBACK

We always welcome your correspondence, feedback, comments, complaints, and suggestions (collectively, "Feedback") as this will help us improve our Services. You agree that all Feedback becomes our confidential information ("Confidential Information"). In addition, any of our trade secrets, computer software, product specifications as well as any non-public technical, financial or business information that we share with you is also our Confidential Information. You agree not to disclose or share any of our Confidential Information with any third party, including, without limitation, any members of the press, colleagues, or competitors. Feedback may be submitted to info@senioradvisorsplus.com.

CONDITION OF SIGNEE

By signing this Agreement, you agree that you are not acting under duress or undue influence.

DISCLAIMERS

By using the Services, you understand and acknowledge that the investment results you could obtain from investment information and financial insights provided by SAP cannot be guaranteed. All investments entail a risk of loss and you may lose money. You also understand that all investments are subject to various market, currency, economic, political, business and other risks. Investments, particularly those in international stocks and stocks of smaller companies, present numerous risks, can be very volatile and can result in a loss of principal. International investments include risks of currency fluctuation, political and economic instability and differences in financial reporting in addition to the risks present in domestic investments. Investments in smaller companies may involve greater risks than investments in larger, more mature companies. The value of debt securities frequently is reduced (sometimes dramatically) by increases in interest rates. While the financial insights we provide may assist in helping you manage your finances, you should consult with a professional investment advisor before making investment decisions or deciding on significant changes to your personal financial strategy.

SAP estimates the total cost of care or services that you or your loved one may need. As a part of our Services, we may make assumptions about the cost of the care provider or servicer, the level of care or service, breadth of care or service, and the timing of the

care or service that you or your loved one may need. As a result, actual costs may differ from our assumptions. SAP will perform reasonable diligence to estimate the costs of care that we expect you or your loved one to incur; however, you understand and agree that SAP will not be held responsible for any inaccuracy of its estimates and that you are responsible for bearing the risks associated with incurring costs that are different from our estimate.

While we may suggest the affordability of a facility, provider, or service is contingent on you receiving (a(n)) subsidies, insurance claims, VA benefits, Medicare claims, Medicaid claims, government waivers, or monetization of assets or combination thereof, we do not make any guarantees of the amount and timing that we expect you to receive from these potential sources of value. Furthermore, SAP's affordability analysis uses assumptions about market conditions, rates of return, discount rates, income sources, mortality, pensions, estates, Social Security, taxes, and portfolio allocation. Actual results of any of these factors may differ from our estimates. SAP will perform reasonable diligence to estimate the amount, value, and timing of the aforementioned factors; however, you understand and agree that SAP will not be held responsible for any inaccuracy of its estimates and that you are responsible for bearing the risks associated with our assumptions differing form actual results.

LIMITATION OF LIABILITY

YOU EXPRESSLY UNDERSTAND AND AGREE THAT SAP WILL NOT BE LIABLE FOR ANY DIRECT, INDIRECT, INCIDENT, SPECIAL, PUNITIVE, COMPENSATORY, CONSEQUENTIAL OR EXEMPLARY DAMANGES RESULTING FROM (A) THE USE OF THE SERVICES (B) THE COST OF THE SERVICES (C) DISCLOSURE OF, UNAUTHORIZED ACCESS TO OR ALTERATION OF YOUR INFORMATION (D) INFORMATION YOU SUBMIT OR RECEIVE (E) CONDUCT OF ANY PROVIDER (F) ANY OTHER MATTER RELATING TO THE PROVIDER. THESE LIMITATIONS SHALL APPLY TO THE FULLEST EXTENT PERMITTED BY LAW. TO THE EXTENT SAP IS FOUND LIABLE FOR ANYTHING RELATED TO THIS AGREEMENT, SAP'S LIABILITY FOR DAMAGES SHALL NOT EXCEED THE FEE PAID BY YOU.

NO THIRD PARTY BENEFICIARIES

This Agreement shall not be construed to create any rights or remedies in any third party.

SAP's FEES

You understand that by signing this agreement you are opting to use SAP's Advisory Service and that you know the difference between SAP's Advisory Service and its Referral Service. We charge **$1,200** upfront for our Advisory Service.

PAYMENT

You may pay by check, card, or cash. Please hand all payments to your representative or send them to:

Senior Advisors Plus
3901 Connecticut Ave. NW Suite 106, Washington, D.C. 20008

If you want to pay by check, please address the check to Senior Advisors Plus, LLC. If you would like to pay by card, please call one of our personnel at (540)330-4103.

_____ _____

Authorized Signee's Signature Date (mm/dd/yy)

CLIENT'S CONSENT TO DISCLOSURE AND USE OF PROTECTED DATA

The undersigned, as the client or their representative, hereby consents to the disclosure of the client's identity, identifiable information, and such financial, personal and medical information (the "Protected Data") in accordance with the following terms and conditions. The client herein is defined as the person who SAP will recommend a community, provider, home caregiver, or service for. In the event that someone(s) other than the client is helping to pay for the client's needs and the client or representative would like SAP to consider the other payers financial fitness, then the client or their representative, hereby consents to the disclosure of the other payers identity, identifiable information, and such financial, personal and medical information (the "Protected Data") in accordance with the following terms and conditions.

INFORMATION AUTHORIZED TO BE DISCLOSED:

I understand that the Protected Data that may be disclosed to SAP includes, but is not limited to: names; addresses; personal identifying information, including, but not limited to, my date of birth, and family members; information gathered from phone screenings, web correspondence, in-person conversations, and mailings with me, family members, financial representatives, financial advisors, providers, doctors, health care facilities, any other parties that would be helpful in determining a suitable senior care facility or service for me; information held by the Insurer regarding me or my insurance Policy; financial information from me, my family, guardians, laywers, and financial representative(s) that me or my family does business with, including but not limited to: brokers, advisors, attorneys, guardians, and representatives; and medical records and information.

CLASSES OF PERSONS AUTHORIZED TO DISCLOSE MY PROTECTED DATA:

I authorize Senior Advisors Plus, LLC, its subsidiaries, series, and affiliates, collectively referred to in this Agreement as "SAP"; any health care provider; doctor; physician; medical practitioner; nurse, pharmacy; physician practice group; hospital; clinic; medical facility; insurance support organization; government agency; insurance company; group policyholder; employer; benefit plan administrator; prescription drug database; pharmacy benefit manager; medical information bureau; medical information clearinghouse; nursing home; assisted living community; independent living community; memory care community; senior care facility; financial advisor; financial group; financial representative; family member(s); care manager; social worker; nurse; or any other institution or person having any of my Personal Data (collectively referred to as "Authorized Persons") to disclose any and all of my Personal Data as provided under this authorization. I agree that a photostatic or facsimile copy or other reproduction of this authorization shall be valid as the original.

CLASSES OF PERSONS AUTHORIZED TO RECEIVE MY PROTECTED DATA:

I authorize each of the Authorized Persons to disclose to, or to permit inspection and/or copying of all my Protected Data to SAP; SAP's authorized representatives, designees, successors, or assigns; any of the communities, facilities, services, providers, or homes that SAP does, did, or plans to recommend you to; insurers; financial advisors; financial groups; family members; and any of the respective affiliates, directors, officers, employees, agents, authorized representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately foregoing clause, inclusive (each an "Authorized Recipient" or collectively "Authorized Recipients"). I understand that my Protected Data may be secured by a third-party provider and may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website. I permit Authorized Persons and Authorized Recipients to send and receive my Protected Data electronically via an email, whether it's secured or not.

AUTHORIZED PURPOSES

I hereby authorize the release of Protected Data to Authorized Recipients for any purposes permitted by law, including, but not limited to: (i) allowing SAP to gather information about me to be able to search for a community or service to recommend to me; (ii) allowing SAP to perform certain health analysis to recommend the type of care that is suitable for me; (iii) allowing SAP to perform certain financial analysis of me to recommend the type of care that I can afford, subject to SAP's financial and medical assumptions; (iii) allowing senior care communities, services, groups, homes, and networks to estimate the type of care that is suitable for me; (iv) allowing insurers to estimate whether they will cover a portion or all of the cost of the care that I may seek; (v) the use, disclosure and reproduction by the Authorized Recipients' actuaries, attorneys, accountants, auditors, staff, managers, executives, or other service providers in the performance of services by them for, on behalf of, or at the direction of the Authorized Recipients or in their evaluation of any process, procedure or obligation of the Authorized Recipient.

Each of the undersigned certifies that this Authorization has been made freely, voluntarily and without coercion. Each of the undersigned understands that any revocation of this Authorization will not apply to information that has already been released in reliance on this Authorization. Re-disclosure of the Protected Data by those receiving it pursuant to this Authorization may be accomplished without any further consent or authorization and may no longer be protected. Each of the undersigned releases any Authorized Recipient from any and all liability for actual or alleged damages to the undersigned as a result of good faith compliance with this Authorization. Each of the undersigned acknowledges receipt of a copy of this Authorization. A copy of this Authorization may be accepted as an original. This Authorization may be sent via facsimile transmission.

_____ _____

Authorized Signee's Signature Date (mm/dd/yy)

AUTHORIZATION FOR RELEASE AND USE OF PROTECTED HEALTH INFORMATION

I, the undersiged insured(s), client(s), or authorized representative(s), authorize the disclosure of the client's Protected Health Information (as that term is defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations")) ("PHI"). The client herein is defined as the person who SAP will recommend a community, provider, home caregiver, or service for.

CLASSES OF PERSONS AUTHORIZED TO DISCLOSE MY PHI:

I authorize Senior Advisors Plus, LLC, its subsidiaries, series, and affiliates, collectively referred to in this Agreement as "SAP"; any health care provider; doctor; physician; medical practitioner; nurse, pharmacy; physician practice group; hospital; clinic; medical facility; insurance support organization; government agency; insurance company; group policyholder; employer; benefit plan administrator; prescription drug database; pharmacy benefit manager; medical information bureau; medical information clearinghouse; nursing home; assisted living community; independent living community; memory care community; group-home; home caregiver; or senior care facility; financial advisor; financial group; family members; or any other institution or person having any of my PHI (each an "Authorized Person" or collectively "Authorized Persons") to disclose any and all of my PHI as provided under this authorization. I agree that a photostatic or facsimile copy or other reproduction of this authorization shall be as valid as the original.

CLASSES OF PERSONS AUTHORIZED TO RECEIVE MY PHI:

I authorize each of the Authorized Persons to disclose to, or to permit inspection and/or copying of all my PHI to SAP; SAP's authorized representatives, designees, successors, or assigns; any of the communities, facilities, providers, or homes that SAP does, did, or plans to refer clients to; insurers; financial advisors; financial groups; family members; and any of the respective affiliates, directors, officers, employees, agents, authorized representatives, independent contractors, accountants, actuaries, attorneys and other representatives and advisors, and successors and assigns of any of the persons or entities covered in the immediately foregoing clause, inclusive (each an "Authorized Recipient" or collectively "Authorized Recipients"). I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to an Authorized Recipient, including transmission via web posting to a secure website. I permit Authorized Persons and Authorized Recipients to send and receive my PHI electronically via a secured email.

DESCRIPTION OF PHI AUTHORIZED FOR DISCLOSURE AND PURPOSE OF DISCLOSURE:

This authorization applies to any and all of my health and medical data, information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations (including any physical or mental condition and psychiatric care, condition, drug and alcohol abuse and treatment, whether voluntary or involuntary), including any underlying data or materials obtained from other sources, regarding my health, care, and treatment, including test data and medical billing. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient: (i) to analyze, assess, evaluate or underwrite my health or medical condition as it relates to referring me to the appropriate type of community or at-home care provider, life expectancy, or type of insurance as it relates to estimating whether my insurance will cover any of the costs associated with the care SAP is helping me to find. I understand that insurers may not reimburse me for a portion or any amount that SAP predicted they would, and I do not hold SAP liable for any amount of compensation for such analysis and recommendations that deviates from reality. I authorize that SAP may re-disclose my PHI to (i) nursing homes; (ii) assisted living communities; (iii) independent living communities; (iv) memory care community; (v) senior care facility; (vi) group homes; (vii) or any other institution, facility, home, practitioner, doctor, or business I have ask SAP to help me find.

EXPIRATION OF AUTHORIZATION:

This authorization shall remain valid until one (1) year after the date of my death. If state law limits the amount of time in which this authorization shall remain valid then this authorization is valid from _____ to _____, or for as long as is permitted by state law.

RIGHT TO REVOKE AUTHORIZATION:

I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Person or Authorized Recipient by notifying such Authorized Person or Authorized Recipient in writing or by email. A written revocation must be sent to 3901 Connecticut Ave NW, Suite 106 Washington, D.C. 20008. A revocation by email must be sent to info@senioradvisorsplus.com

Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization:

No Authorized Person or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

AUTHORIZATION NOT REQUESTED BY A HEALTH CARE PROVIDER:

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the HIPAA Privacy Regulations.

POTENTIAL FOR RE-DISCLOSURE:

I further understand that, as a result of this authorization, there is the potential for any of my PHI that is disclose by any Authorized Person to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and that any portion of my PHI that was protected by the HIPAA Privacy Regulations may no longer be protected once disclosed to such Authorized Recipient.

CERTIFICATION:

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

COUNTERPARTS:

This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which, taken together, shall constitute but one and the same instrument.

AUTHORITY TO SIGN:

Each person signing this Agreement on behalf of an entity or person represents and warrants that he or she is fully authorized to execute this Agreement on behalf of the entity or person on whose behalf such individual has signed this Agreement, and that by signing this Agreement such entity or person shall be bound by the terms contained in this Agreement.

_____
Name of SAP Representative

_____ _____
SAP Representative Signature Dated (mm/dd/yy)

By signing below, the Client or Client's Representative acknowledges that he or she has received, read, and agreed to the terms of this Agreement:

_____
Client Representative's Relationship to Client

_____ _____
Client Name Client Representative Name

_____ _____
Client or Client Representative Signature Dated (mm/dd/yy)