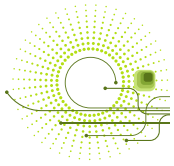




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Funding Application

Medical

Living Expenses

Both

The following information is necessary before application can be processed. To avoid delays in approval process please ensure all requested information is provided. Once completed please fax to 888.355.4800

Date: _____

Amount requested: _____

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: _____

SSN: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Fax: _____

Your Insurance: _____

Defendant's Insurance: _____

Policy Limits: _____

Were you employed? No Yes

Has Liability been established? No Yes

Healthcare Provider Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

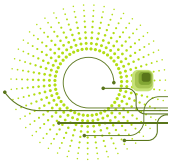
Email: _____

Contact Name: _____

Treatment/ Condition: _____



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Attorney Information

Attorney Name:

Law Firm Name:

Address:

City:

State:

Zip:

Phone:

Fax:

Email:

Secretary/ Paralegal Name:

Type of Case:

- Motor Vehicle Slip/ Fall Medical Malpractice Product Liability Wrongful Death
- Wrongful Termination Commerical Fraud Breach Worker's Compensation
- Appellate Patent & Copyright Infringement Other: _____

Case Status: _____

Applicant Release

I, the applicant, is hereby authorizing CarePoint Financial Services, their agents, lending institutions and underwriters to review all the confidential information of my case, and underwrite my case on an exclusive basis.

Print Name:

Date:

Signature:

Date: