carePOINT

316 Wilcox Street, Castle Rock, CO 80104 T: 303.660.0111 • 888.355.4800 F: 877.660.0111 www.carepointfinancial.com

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: _____