Pink Fishing, Inc.

Application for Limited Financial Assistance

P. O. Box 1445 ♦ Copperas Cove, Texas 76522
(254) 289-0394 or 325-665-0424
Web site: www.pinkfishing.com

In order to be eligible for limited financial assistance you must:
Have a diagnosis of breast cancer confirmed by an oncology health care provider
Be in active treatment for your breast cancer - Be a U.S. Citizen

<table>
<tr><th colspan="6">Applicant Information - Required</th></tr>
<tr><td colspan="6">Name must be entered as shown on your Social Security card.</td></tr>
<tr><td>Social Security Number</td><td colspan="2">First Name</td><td>Middle Name/Initial</td><td colspan="2">Last Name</td></tr>
<tr><td colspan="2">Mailing Address</td><td colspan="2">City</td><td>State</td><td>ZIP Code</td></tr>
<tr><td>Phone
______-______-______</td><td>Email</td><td colspan="4">Date Received (For internal use only)
______/______/______</td></tr>
<tr><td colspan="6">Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed</td></tr>
</table>

Instructions

- You must submit a completed application. Please print clearly—illegible applications cannot be processed. Fill in each blank space in the application.
- Briefly describe why assistance is needed and type of assistance requested... co-pay, gas, lodging for family. Attach to application.
- Have an oncology health care provider complete section of the Physician Verification/Documentation and provide a signature and date. **You cannot complete this section.**
- Please mail the completed form to the address located on the top of this form.

Pink Fishing, Inc. Applicant Certification - Required

I_____________________________________ (print full name) declare that the above information and the accompanying physician verification/documentation that I am actively receiving treatment for Breast Cancer is true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any documents are found to be incorrect, incomplete, false, or misleading, I will be required to repay all assistance received from Pink Fishing, Inc. plus interest. This certification authorizes Pink Fishing, Inc. to verify with my Oncologist that I am actively receiving treatment for Breast Cancer. This authorization to release information is confirmed by the signature below. This authorization shall become effective immediately and shall remain in effect for one year from the date of signature or until Pink Fishing, Inc. has ceased providing services to you, whichever is longer. I reserve the right to withdraw this authorization at any time by written notification to Pink Fishing, Inc.. I understand that revocation of this authorization will not affect any action Pink Fishing, Inc. took in reliance on this authorization prior to Pink Fishing, Inc.'s receipt of my written notice of revocation.

Applicant Signature: ____ Date Signed____________________

Physician Verification/Documentation - to be signed by treating physician

I_____________________________________ (print physician full name) declare that said applicant is actively receiving treatment for Breast Cancer. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law.

Physician Signature____ Date Signed_____________________

Consent to the disclosure of Health Information for Financial Assistance
Your rights and privacy are protected by law.

As an applicant for assistance, you will be asked to share some of your medical information with Pink Fishing, Inc. Your medical information is protected by law and can only be shared with your permission. Your personal medical information consists of:

Your Social Security number
Your full legal name
Your address
Your phone number
Your marital status
Your physician verification of actively receiving breast cancer treatment

I fully understand and consent to such disclosures of protected health information and the terms of this consent.

Applicant Signature: ____ Date Signed____________________