

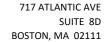


PHONE (888) 241-7534 FAX (617) 507-1085

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APPLICATION

Contact Info	ormation:						
Claimant Infor	mation:						
	Full Name:						
	Nickname:						
	Street Address						
	City	StateZip					
	Home Phone No.:	Fax No					
	Email Address:	Cell No					
	Birth Date:	Social Security No					
	Gender: □ Male □ Female	e					
	Marital Status: Single/Married/ Divorced/Separated						
	Dependents: Yes/No (If yes, please list)						
	Work Status: Employed/ Ur	nemployed/ Permanent Full Disability					
	* · ·	Alone/ With Family/ Assisted Living/ Res	sidentail Facility				
	0 0	, ,,	,				
Guardian/ Ad	lvocate Information						
	Name:						
	Address:						
		StateZip					
	Phone No.:	Fax No.:					
	Email:						
Settlement	Information:						
Date of Settlem	nent:						
Annuity Provid	ler:	Annuity: \$	m/a/q/s				
Broker	Name of Company						
	Name of Contact						
	Telephone No	Fax No					
	-	Cell No.					
Other Contact							
	Name:						
	Phone:						

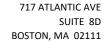




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Injury/Disa	ability						
Disabled Person	n Suffers from:						
	Nature of Injury/Disability:						
	Date of Injury:						
Eligibility I	Information						
	Workers Compensation: Yes / No						
	Private Insuran	nce: Yes / No					
		If yes, name					
Disabled Perso	on Receives:						
	□ SSI and Med	licaid- Amount of SSI: \$					
	□ SSI Only- Amount of SSI: \$						
	□ SSDI and Medicare - Amount of SSDI: \$						
	□ Medicare- M	Tedicare Coverage: Part A Part B Both					
	□ Medicaid Wa	iver					
	□ Section 8 Ho	ousing					
	□ Group Hom	e					
	□ Facility						
		sability Benefits					
	□ Other Public Benefits						
If Disabled Pe	rson is not receiv	ring any of these benefits, which, if any, have the filed for?					
11 21045104 1 0	□ SSI:	Date of Filing:					
	_ 555.	Has there been a determination of disability by the Social Security Administration?					
		□Yes □No					
	□Medicaid						
	□Medicaid Wai	iver					
	□SSDI Date of						
	□ Medicare:	Is the Disabled person likely to be eligible for Medicare within 30 months					
		□Yes □No					
Other Income	, if applicable						
		Benefit Income (eg., food stamps): \$					
	Pension Income (if any): \$						
	Montly Income from Employment: \$						
	Any other inco						





Immediate Distributions

Pro Rata Budget □Yes

Truelink

Budget:

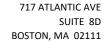
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Home					
	Is a home purchase being considered?				
		□Yes	$\square No$		
	If yes, estimated an	nount of purchase?			
Vehicle					
	Will a vehicle be purchased to meet the transportation needs of the disabled person?				
	Budget (\$40,000 standard vehicle/\$80,000 accessible)				
		□Yes	$\square No$		
ABLE Account	Lump Sum Funding / Annuity Funding				
Paid Caregiving	□Yes	$\square No$			

□No

If yes, please fill out "Current Monthly Obligations"





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CURRENT MONTHLY OBLIGATIONS

Home expenses (montly total)		Transportation (monthly total)				
Do you:		Do you own a	car?			
	□Own		□Yes			
	□Rent		□No			
Rent: \$		If yes,				
Mortage: \$			Year			
Property Tax: \$			Make			
Insurance: \$			Model			
Gas: \$			Car Payment: \$			
Electrical bill: \$			Insurance: \$			
Water bill: \$			Monthly Gas: \$_			
Sanitation bill: \$	<u> </u>		Maintenance: \$			
Groceries: \$						
Meals Outside t	:he Home: \$					
Phone bill: \$		Current Obligations:				
Cell phone bill:	\$	Please indicate	Please indicate even if past due or delinquent			
Cable bill: \$		Credit Cards:				
Internet: \$			Card type	Current Balance		
Other (specify):	\$					
Miscellaneous	Expenses (monthly total):					
Insurance						
	Life: \$					
	Health: \$					
	Disability: \$					
Medical bills:	,					
	Doctor: \$	Other Obliga	tions (eg. Medical b	oills, student loans, past due taxes)		
	Medications: \$	0	Туре	Current Balance		
	Therapy: \$		71			
	Medical Suppy: \$					
Clothing: \$	***					
	\$					
	ses: \$					
*	\$					
Income Tax pay				_		

The completion of this Questionnaire should not be deemed an aproval nor denial of any trust distribution request.