The Reggie White Sleep Disorders Research and Education Foundation
Financial Hardship Application

<table>
<tr><td colspan="4">Please provide the following information completely and accurately. Information is subject to verification.
For additional household members, please attach a list with information as noted below.</td></tr>
<tr><td>Patient's Name (First, MI, Last):</td><td colspan="2">Social Security Number:</td><td>Date of birth:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Telephone Numbers: Cell: ( )
Home: ( ) Work: ( )</td></tr>
<tr><td colspan="2">City/State/Zip Code:</td><td colspan="2">Responsible Party Name (First, MI, Last):</td></tr>
<tr><td>List ALL household member names:</td><td>Date of Birth:</td><td>Soc. Sec. Number:</td><td>Relationship to Patient:</td></tr>
<tr><td>1.</td><td></td><td></td><td></td></tr>
<tr><td>2.</td><td></td><td></td><td></td></tr>
<tr><td>3.</td><td></td><td></td><td></td></tr>
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<table>
<tr><td colspan="2">Household Monthly Income</td><td colspan="2">Additional Employers Write on Back of Application</td></tr>
<tr><td>Household Income (before taxes)
Attach copy of Federal returns if filed or W2's</td><td>$</td><td>Employer</td><td>Phone Number</td></tr>
<tr><td>Pension/Retirement/Unemployment
Attach copy of 1099's or documents</td><td>$</td><td>Hire Date</td><td>Termination Date</td></tr>
<tr><td>Rental Property Income,
Investment Income (annuities/Stocks/Dividends)</td><td>$</td><td colspan="2">Are you covered under a Health Insurance Plan?
yes no</td></tr>
<tr><td>Child Support/Alimony Received
Attach proof of monthly support</td><td>$</td><td colspan="2">Name of Insurance</td></tr>
<tr><td>Other</td><td>$</td><td colspan="2" rowspan="2">Total Medical Bills (attach list) optional
$</td></tr>
<tr><td>Total Monthly Income</td><td>$</td></tr>
</table>

Please provide complete copy of _____ Federal tax returns or W2's if you did not file taxes.

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at the time of registration. I understand that providing false information will result in denial of application for any type of financial assistance through The Reggie White Foundation. If I am entitled to any action or settlement from third party payers, I will take any action necessary or requested by The Sleep Wellness Institute to obtain such reimbursement and will assign to The Reggie White Sleep Disorder Research and Education Foundation, and upon receipt will pay to The Reggie White Sleep Disorder Research and Education Foundation all the amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such reimbursement or to follow through with the application process or take those actions reasonably necessary or requested by The Sleep Wellness Institute will result in the denial of this application. I also authorize The Reggie White Sleep Disorder Research and Education Foundation to check my credit history through the credit bureau, if deemed appropriate.

Please completed application and send to:

The Reggie White Sleep Disorders Research and Education Foundation
2322 Morning Park Drive
Katy, TX 77494

______________________________ ______________________________
Signature of Patient (Responsible Party) Date

______________________________ ______________________________
Approvers Signature Date