

BOSTONGENE OFFERS A FINANCIAL ASSISTANCE PROGRAM TO PROVIDE ALL PATIENTS AN OPPORTUNITY TO RECEIVE THE TEST NECESSARY FOR CLINICAL DECISION MAKING AND TO HELP PATIENTS IN NEED TO DECREASE THEIR OUT-OF-POCKET EXPENSES.

WE BELIEVE EACH PATIENT SHOULD HAVE ACCESS TO MEDICALLY NECESSARY TESTS ORDERED BY YOUR PHYSICIAN.

PLEASE FILL THIS FORM TO APPLY FOR THE BOSTONGENE FINANCIAL ASSISTANCE PROGRAM.

BOSTONGENE WILL CONSIDER THE FINANCIAL APPLICATION TAKING YOUR HOUSEHOLD INCOME AND OTHER LIFE CIRCUMSTANCES INTO ACCOUNT.

*REQUIRED FIELDS MUST BE FILLED OUT.

| PATIENT INFORMATION: | | | | | |
|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------|----------------------------|----------------------------|
| FIRST NAME* | | | LAST NAME* | | |
| DATE OF BIRTH* | | | SEX | <input type="checkbox"/> M | <input type="checkbox"/> F |
| PHONE | | EMAIL | | FAX | |
| STREET ADDRESS | | | CITY | | |
| STATE | <input type="checkbox"/> YES | <input type="checkbox"/> NO | COUNTRY | | POSTAL CODE |
| PREFERRED METHOD OF CONTACT | <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> FAX <input type="checkbox"/> MAIL TO HOME ADDRESS | | | | |

| PATIENT BACKGROUND: |
|------------------------------------------------------------------------------------------------|
| PATIENT GROSS ANNUAL HOUSEHOLD INCOME (ESTIMATE)* |
| HOW MANY FAMILY MEMBERS ARE IN YOUR HOUSEHOLD?* |
| PLEASE INDICATE ANY SPECIAL CIRCUMSTANCES (E.G. MEDICAL OR CREDIT CARD DEBT/LOST JOB RECENTLY) |
| |

| ORDERING PHYSICIAN INFORMATION: | |
|---------------------------------|-----------|
| FIRST NAME | LAST NAME |
| INSTITUTION | |
| PHONE | EMAIL |

| PATIENT CONSENT TO APPLICATION: | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| ARE YOU A PATIENT? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| IF NOT, PLEASE INDICATE YOUR NAME AND RELATIONSHIP TO THE PATIENT | |
| <small>BY SIGNING THIS FORM, I CERTIFY THAT ALL THE INFORMATION PROVIDED IN THE APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BOSTON GENE TO USE THE INFORMATION PROVIDED IN THIS APPLICATION TO DETERMINE MY ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAM</small> | |
| SIGNATURE* | DATE* |