



For information about this application, call
1-888-689-9876

Please fax this application to
416-487-0251

www.faceforward.ca

APPLICANT'S INFORMATION

Primary Applicant <input type="checkbox"/> Co-Applicant <input type="checkbox"/>	If Co-Applicant, state primary applicant name here:			Contact Before Faxing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/>	First Name & Initial(s):		Last Name:	
Home Phone Number:	Other Phone Number (Day):	Fax Number:	Email:	
Present Address:		Apt. #:	City:	Prov.:
		Postal Code:	How Long At This Address?:	
Own <input type="checkbox"/> Rent <input type="checkbox"/>	Monthly Rent Or Mortgage: \$	Mortgage Lender:	Social Insurance # (Optional in Québec):	Driver's License # + Province (Optional in Québec):
Occupation:		Present Employer (Company Name):	Contact Name:	Employer's Phone Number:
				Length of Employment:
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Student <input type="checkbox"/>	Gross Monthly Income: \$		Net Monthly Income: \$	Other Income (Specify):
If Self Employed: State Name of Source of Income/Accountant:			Accountant's Phone Number:	
Name of Bank:	Branch Address:	Telephone Number:	Chequing <input type="checkbox"/> Savings <input type="checkbox"/> Account Number:	

ABOUT CO-APPLICANT

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/>	First Name & Initial(s):		Last Name:	
Home Phone Number:	Other Phone Number (Day):	Fax Number:	Contact Before Faxing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Present Address:		Apt. #:	City:	Prov.:
		Postal Code:	How long at this address?:	
Own <input type="checkbox"/> Rent <input type="checkbox"/>	Monthly Rent Or Mortgage: \$	Social Insurance # (Optional in Québec):	Driver's License # + Prov. (Optional in Québec):	Date of Birth: d/m/y
Occupation:		Present Employer (Company Name):	Contact Name:	Employer's Phone Number:
				Length of Employment:
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Self Employed <input type="checkbox"/> Student <input type="checkbox"/>	Gross Monthly Income: \$		Net Monthly Income: \$	Other Income (Specify Amount):
If Self Employed: State Name of Source of Income/Accountant:			Accountant's Phone Number:	
Name of Bank	Branch Address	Telephone No.	Chequing <input type="checkbox"/> Savings <input type="checkbox"/> Account Number:	

Upon approval, Medicaid® will contact your doctor's office or Medical Treatment Facility. If you require an immediate answer or have special instructions or information indicate in the space provided here:

Pursuant to the provisions of the Criminal Code of Canada anyone who obtains credit by a false pretense or a false statement is guilty of a criminal offence.

I/we are interested in the Optional Creditors Life & Accidental Disability Insurance Program. I/we understand that it is not required in order to obtain credit. The Creditor's Life Insurance program protects my/our account for the balance of the loan, to be paid in full, if the borrower(s) should die. The Accidental Disability Program protects my/our account for the monthly payment if the borrower(s) should become totally disabled due to injury. The cost of the insurance will be added to my/our loan at a cost of \$1.50 per \$100.00 per year for single and \$2.70 per \$100.00 per annum for joint insurance. For further information, contact Medicaid®. Underwritten by subsidiaries of The Canada Life Assurance Company. *Applicable to the loan program only.

If you are a business owner and interested in deducting 100% of your medical expenses, check here for more information.

TERMS AND CONDITIONS

I understand that the above information (the "Collected Information") is being collected for the purpose of obtaining credit from Medicaid Finance Inc. ("Medicaid") and is warranted to be true and complete. I hereby authorize and consent to the collection of the Collected Information and to the making by Medicaid, its successors and assigns of whatever credit investigations and/or employment and income confirmations Medicaid or its successors and assigns may deem appropriate from time to time, and to the disclosure, sharing or exchange of the Collected Information and any report or information based thereon for these purposes with credit reporting agencies, and amongst Medicaid, its successors and assigns or any company with whom I have or propose to have a financial relationship. This consent is given to meet the requirements of applicable credit reporting legislation and to fully comply with all laws and regulations in Canada regarding the collection, use and disclosure of personal information.

X _____ Date: _____ **X** _____ Date: _____
Signature of Applicant Signature of Co-Applicant (only if applicable)

\$ _____ Approximate Date of Procedure Loan Term 6 Mo. 1 yr. 2 yrs. 3 yrs. 4 yrs.
Amount of Financing Required _____

Patient Name Medical Clinic and Doctor's Name Clinic Phone Number

