September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ___ - ___ - ____

SEPTEMBER 11TH VICTIM COMPENSATION FUND
ELIGIBILITY FORM FOR PERSONAL INJURY CLAIMANTS

Eligibility Form
(Parts I- IV)

PART I. CLAIMANT AND CLAIM INFORMATION

A. GENERAL CLAIMANT INFORMATION

Claimant's Last Name

First Name

Middle Name

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Country

Email Address

Date of Birth (mm/dd/yyyy)

Telephone Number (Home)

Telephone Number (Work)

Telephone Number (Mobile)

Country of Citizenship

Social Security or National ID Number

Passport Country (if not U.S.)

Passport Number (if not U.S. and available)

○ Please indicate if you would like correspondence to be provided via e-mail. Please note, selecting this option will require you to register at www.VCF.gov.

1139063430

B. INFORMATION ABOUT THE CLAIMANT'S GUARDIAN OR OTHER AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Please complete this Section B only if the Claimant has a guardian or someone other than the injured Claimant is submitting this form. (**Note**: If represented by an attorney, attorney information should be provided in Section C, not in this Section B).

Representative's Last Name

First Name

Middle Name

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Country

Email Address

( ) - Telephone Number (Home)

( ) - Telephone Number (Work)

( ) - Telephone Number (Mobile)

Country of Citizenship

- - Social Security or National ID Number

Passport Country (if not U.S.)

Passport Number (if not U.S. and if available)

B. INFORMATION ABOUT THE CLAIMANT'S GUARDIAN OR OTHER AUTHORIZED REPRESENTATIVE (IF APPLICABLE) (continued)

Representative's relationship to the Claimant:

○ Parent of minor

○ Indicate here if you have sole legal custody of the minor

○ Indicate here if you have joint legal custody of the minor

Note: If you share or have joint custody of the Claimant with someone else, both signatures are required wherever this claim form asks for a signature.

If you have joint legal custody of the minor, please complete the joint custody information section below for the person with whom you share custody:

Last Name

First Name

Middle Name

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Country

Email Address

( ) - Telephone Number (Home)

( ) - Telephone Number (Work)

( ) - Telephone Number (Mobile)

- - Social Security or National ID Number

Country of Citizenship

Passport Country (if not U.S.)

Passport Number (if not U.S. and available)

○ Guardian of minor

○ Guardian of non-minor

○ Representative of deceased individual who is alleged to have suffered physical harm covered by the Zadroga Act but whose death is *not* claimed to have resulted from those crashes or debris removal efforts.

See Instructions for important additional information that must be provided with this claim.

○ Other

Explanation

Please note: The authorized representative must submit proof of his/her authority to act on behalf of the Claimant in order for the VCF to process the claim. See Instructions and Supporting Document Checklist at the end of this form.

C. INFORMATION ABOUT THE CLAIMANT'S ATTORNEY OR ALTERNATE CONTACT PERSON (IF APPLICABLE)

If an attorney or other authorized individual is assisting the Claimant with this claim, please indicate and fill out the information below:

○ Attorney

○ Other Individual

Title:

Relationship to Claimant:

Last Name

First Name

Middle Name

Law Firm or Organization

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Country

Email Address

( ) -

Telephone Number

○ The Claimant should indicate here and complete the certification at Part IV.F (Authorization of Attorney Communication and Correspondence) if the Claimant authorizes the VCF to communicate with this individual about his/her claim. The Claimant may also indicate at Part IV.F if he/she would like to receive a copy of all VCF written correspondence regarding his/her claim.

D. INFORMATION ABOUT THE CLAIMANT'S PRIOR CLAIM WITH THE SEPTEMBER 11TH VICTIM COMPENSATION FUND (IF APPLICABLE)

Was a claim previously filed by or on behalf of the Claimant with the original September 11th Victim Compensation Fund of 2001? O Yes O No

If no, please proceed to Part I.E.

If yes,

- What injury/injuries did the Claimant allege in connection with the prior claim?

  Please Specify

- Was a payment issued on the claim? O Yes O No O Do not know

  If no, was the claim denied/determined to be ineligible? O Yes O No

  - If yes, what was the basis for the ineligibility determination?
    - O Outside the original Victim Compensation Fund zone
    - O Did not sustain physical harm
    - O Did not sustain physical harm within requisite timeframe
    - O Other reason for ineligibility Please Specify
    - O Do not know

  If yes,

  - For what injury/injuries was the Claimant previously compensated?
    - O Traumatic Injury Please Specify
    - O Respiratory or other latent injury Please Specify
    - O Other
    - O Do not know

- Was the Claimant compensated for any disability or future lost wages? O Yes O No O Do not know

  If yes, was it for a: O Permanent disability O Temporary disability

- Which of the following categories describes the Claimant's current circumstances? (Select any that apply)

  - O The Claimant now suffers from an injury that the Claimant had not suffered at the time the Claimant filed the previous claim with the Victim Compensation Fund
  - O The Claimant suffers from an injury that the Claimant did not reasonably know of at the time that the Claimant filed the previous claim with the Victim Compensation Fund
  - O The Claimant suffers from a condition that the Special Master has identified as a presumptively covered condition since the time the Claimant filed the previous claim with the Victim Compensation Fund
  - O The Claimant is claiming the same injury for which the previous Victim Compensation Fund claim was filed but that injury has substantially worsened, resulting in damages or loss that was not previously compensated.
  - O The Claimant's presence at a 9/11 crash site fell outside the eligibility requirements of the original September 11th Victim Compensation Fund of 2001 but now satisfies the requirements based on amendments contained in Title II of the Zadroga Act (e.g., the Claimant was present outside of zone of danger defined by the original Victim Compensation Fund).
  - O Other/Do not know Please explain

    Explanation

    Explanation

E. INFORMATION ABOUT THE CLAIMANT'S PARTICIPATION IN LAWSUITS RELATED TO SEPTEMBER 11, 2001 (IF APPLICABLE)

1. Has the Claimant or any dependent, spouse or beneficiary of the Claimant filed a lawsuit or been a party to a lawsuit in any court for damages as a result of the September 11, 2001 attacks (including damages related to debris removal)? (Note: Do not include in this section any lawsuit to recover collateral source obligations (such as insurance or Social Security) or a lawsuit against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act.) O Yes O No

If no, please proceed to Part I.E 2 below

If yes,

Was the lawsuit commenced after December 22, 2003? O Yes O No

Has the lawsuit been dismissed or withdrawn? O Yes O No

If yes, when was the lawsuit dismissed or withdrawn? __ / __ / ____
Date(mm/dd/yyyy)

Has the lawsuit been settled? O Yes O No

If yes,

Did the individual settle all claims? O Yes O No

- If yes,

What was the total settlement amount? __,___,___

What injuries or damages were claimed in the lawsuit? Please specify

- If no, have all unsettled claims been dismissed or withdrawn? O Yes O No

Was a release of all claims in such lawsuit tendered (i.e., signed and submitted) prior to January 2, 2011? O Yes O No

- If yes,

Who tendered (i.e., signed and submitted) the release?

O Individual Claimant

O Claimant's attorney

- Did the Claimant's attorney have authority to sign the release on the Claimant's behalf? O Yes O No (See instructions for further information.)

2. Has the Claimant filed or has any dependent, spouse or beneficiary of the Claimant filed on the Claimant's behalf any other lawsuit or claim with any court or bankruptcy trust for any respiratory injury or disease due to exposure unrelated to September 11, 2001? (An example would be a lawsuit for injuries related to exposure to asbestos.)

If no, please proceed to Part II

If yes,

- Please provide information on any lawsuit or claim (complete for each lawsuit or claim)

Court/Trust:

Year Filed: ____

Docket number:

Injury/disease claimed:

Do not know: O

- Has the lawsuit or claim been completely resolved? O Yes O No

If yes, please provide documentation of the judgment, settlement or trust compensation

If no, has the lawsuit or claim been resolved in part? O Yes O No

- If yes, please provide documentation of the judgment, settlement or trust compensation

PART II. INFORMATION ABOUT THE CLAIMANT'S PRESENCE AT A 9/11 CRASH SITE BETWEEN SEPTEMBER 11, 2001 AND MAY 30, 2002

In this Part, please identify the circumstances and locations (Section A) and corresponding time and duration (Section B) of Claimant's presence at a 9/11 crash site from September 11, 2001 through May 30, 2002

Note: If the Claimant's presence at a 9/11 crash site from September 11, 2001 through May 30, 2002 involved more than one location (for example, if Claimant was a Responder at the WTC and also resided in the NYC Exposure Zone, or if Claimant worked at two different buildings within the NYC Exposure Zone), please make copies of this Part II and complete Part II for each location.

What is the definition of a "Responder" for purposes of this claim form?

A "Responder" is defined as an individual who performed rescue, recovery, demolition, debris cleanup or other related services in the NYC Exposure Zone (defined below), at the Pentagon site or at the Shanksville, PA site in response to the September 11, 2001 terrorist attacks, regardless of whether the individual was a state or federal employee or member of the National Guard or performed the services in some other capacity. Therefore, you may be considered a Responder even if you performed the listed services through a private employer or on a volunteer basis.

What is the "NYC Exposure Zone" for purposes of this claim form?

For purposes of this claim form, the NYC Exposure Zone is defined to include:

- the area in Manhattan south of the line that runs along Canal Street from the Hudson River to the intersection of Canal Street and East Broadway, north on East Broadway to Clinton Street, and east on Clinton Street to the East River; and
- any area related to or along the routes of debris removal, such as barges and Fresh Kills landfill.

A. Circumstances and Location of Presence at a 9/11 Crash Site

1. If the Claimant was a Responder within the NYC Exposure Zone

Please indicate the organization(s) for which the Claimant worked as a Responder from the list below.

- ○ Fire Department of New York (FDNY) (includes fire and emergency personnel, active or retired)
- ○ Police Department of New York City (NYPD) (active or retired)
- ○ Port Authority of New York and New Jersey Police (active or retired)
- ○ Office of the Chief of the Medical Examiner of New York City
- ○ Port Authority Trans-Hudson Corporation (PATH)
- ○ New York City morgue Please Specify
- ○ New York State Law Enforcement (State Troopers)
- ○ New York State Department of Environmental Services
- ○ Other New York State agency Please Specify
- ○ MTA, Transit Authority
- ○ New York City Department of Sanitation
- ○ New York City Department of Design and Construction (DDC)
- ○ Other New York City agency Please Specify
- ○ Federal Law Enforcement (FBI, etc)
- ○ US Corps of Engineers
- ○ US Corps of Engineers Contractor (EE&G)
- ○ US Corps of Engineers Contractor Phillips and Jordan
- ○ U.S. Coast Guard
- ○ National Guard
- ○ Secret Service
- ○ US Environmental Protection Agency
- ○ FEMA
- ○ Other Federal Agency Please Specify
- ○ Volunteer Organization (including Red Cross and Salvation Army). Please Specify
- ○ Volunteer (non-affiliated) Please Specify
- ○ Union member Please specify union and local
- ○ Utility Company (phone/gas/cable/water/electric)
- ○ Construction Company (Steel worker, engineer, transport, debris removal, grappler & excavator, demolition, etc.). Please Specify
- ○ Barge operating company Please Specify
- ○ Trucking company Please Specify
- ○ Trash removal company Please Specify
- ○ Maintenance company Please Specify
- ○ Dust control company Please Specify
- ○ Pest control company Please Specify
- ○ Clergy Please Specify
- ○ Other Please Specify

A. Circumstances and Location of Presence at a 9/11 Crash Site (continued)

Please identify the Claimant's locations within the NYC Exposure Zone during the period beginning September 11, 2001 through May 30, 2002.

- ○ On or adjacent to the pile/in the pit
  Note: The "pile" or "pit" refers to the mound of rubble from the collapse of the WTC buildings and surrounding infrastructure and the geographic area of the collapsed buildings that was the source and location of the long-burning fires. Please specify location
- ○ Office of Chief Medical Examiner
- ○ Pier 6
- ○ Pier 25
- ○ Other Pier Please specify
- ○ Transport barges Please specify/describe
- ○ Other transportation vehicle(s) Please specify/describe
- ○ Staten Island/Fresh Kills Landfill Please specify/describe
- ○ Other Please specify/describe

2. If the Claimant was a Responder at the Pentagon

Please identify the organization(s) for which the Claimant worked as a Responder during the period beginning September 11, 2001 through May 30, 2002.

- ○ Federal Law Enforcement (FBI, etc)
- ○ US Corps of Engineers
- ○ US Corps of Engineers Contractor (EE&G)
- ○ US Corps of Engineers Contractor Phillips and Jordan
- ○ U.S. Coast Guard
- ○ National Guard
- ○ Secret Service
- ○ US Environmental Protection Agency
- ○ FEMA
- ○ Other Federal Agency Please Specify
- ○ Volunteer Organization (including Red Cross and Salvation Army). Please Specify
- ○ Volunteer (non-affiliated) Please Specify
- ○ Union member Please specify union and local
- ○ Other Please Specify

Please identify the location at the Pentagon site where the Claimant was present during the period beginning September 11, 2001 through May 30, 2002

Address

Address

A. Circumstances and Location of Presence at a 9/11 Crash Site (continued)

3. If the Claimant was a Responder at the Shanksville, PA

Please identify the organization(s) for which the Claimant worked as a Responder during the period beginning September 11, 2001 through May 30, 2002.

- ○ Federal Law Enforcement (FBI, etc)
- ○ US Corps of Engineers
- ○ US Corps of Engineers Contractor (EE&G)
- ○ US Corps of Engineers Contractor Phillips and Jordan
- ○ U.S. Coast Guard
- ○ National Guard
- ○ Secret Service
- ○ US Environmental Protection Agency
- ○ FEMA
- ○ Other Federal Agency Please Specify
- ○ Volunteer Organization (including Red Cross and Salvation Army) Please Specify
- ○ Volunteer (non-affiliated) Please Specify
- ○ Union member Please specify union and local
- ○ Other Please Specify

Please identify the location at the Pentagon site where the Claimant was present during the period beginning September 11, 2001 through May 30, 2002

Address

Address

4. If the Claimant claims presence at the site based on residence within the NYC Exposure Zone

Please identify the address of the Claimant's residence during the period beginning September 11, 2001 through May 30, 2002

Address

Address

A. Circumstances and Location of Presence at a 9/11 Crash Site (continued)

5. If the Claimant worked (as a non-Responder) cleaning buildings or performing maintenance work within the NYC Exposure Zone

Identify the name, address, telephone number and email address of the Claimant's employer for the period beginning September 11, 2001 through May 30, 2002 during which the Claimant is alleging presence in the NYC Exposure Zone. If the Claimant had more than one employer during this time period, please print a copy of this page and complete this section separately for each employer.

Employer

Employer's Address

Employer's Address

( ) -
Telephone Number

Email Address

Please identify the name and address of the location where the Claimant worked.
Please complete this Part separately for each location.

Address

Address

6. If the Claimant worked (as a non-Responder) within the NYC Exposure Zone in a capacity *other than* cleaning buildings or performing maintenance work

Identify the name, address, telephone number and email address of the Claimant's employer for the period beginning September 11, 2001 through May 30, 2002 during which the Claimant is claiming presence in the NYC Exposure Zone. If the Claimant had more than one employer during this time period, please print a copy of this page and complete this section separately for each employer.

Employer

Employer's Address

Employer's Address

( ) -
Telephone Number

Email Address

Please identify the name and address of the location where the Claimant worked.
Please complete this section separately for each location.

Address

Address

A. Circumstances and Location of Presence at a 9/11 Crash Site (continued)

7. If the Claimant attended school or a child care or adult care facility within the NYC Exposure Zone.

Identify the name of the school or the child care or adult day care facility that the Claimant attended in the NYC Exposure Zone for the period beginning September 11, 2001 through May 30, 2002.

School/care facility name

School/care facility address

School/care facility address

( ) -
Telephone Number

8. If the Claimant was present within the NYC Exposure Zone in some other capacity (e.g., as a visitor).

Please describe why the Claimant was in the NYC Exposure Zone during the period beginning September 11, 2001 through May 30, 2002:

Description

Description

Description

Description

Please identify the closest location within the NYC Exposure Zone where the Claimant was present during the period beginning September 11, 2001 through May 30, 2002:

Building - identify address

Street - identify address/cross street

Subway/train/station - indentify location

Other - specify location

A. Circumstances and Location of Presence at a 9/11 Crash Site (continued)

9. If the Claimant was present at the Pentagon site (as non-Responder).

Why was the Claimant present at the Pentagon site during the period beginning September 11, 2001 through May 30, 2002?

- O Worked at Pentagon
- O Attended meeting at Pentagon
- O Other Please explain

Identify the name, address, telephone number and email address of the Claimant's employer for the period beginning September 11, 2001 through May 30, 2002 during which the Claimant is claiming presence at the site.

Employer Name

Employer's Address

Employer's Address

( ) -
Telephone Number

Email Address

Identify the location at the Pentagon site where the Claimant was present during the period beginning September 11, 2001 through May 30, 2002.

Address

Address

Address

B. Time and Duration of Presence at the Site.

Please identify on the lines below the specific days and number of hours for each day beginning September 11, 2001 through May 30, 2002 that the Claimant asserts presence at the location identified in Part II.A above (e.g., lived, worked, attended school or was otherwise present at a 9/11 crash site).

Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)	Hours	Location
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C. Proof of Location and Time of Presence and Activities at the Site.

Please see the instructions and document checklist for an explanation of the documents that you must submit to prove that the Claimant was present at a 9/11 crash site.

PART III. INFORMATION ABOUT THE CLAIMANT'S PHYSICAL INJURY

Did the Claimant suffer physical harm as a result of one of the air crashes and/or the debris removal? ○ Yes ○ No

If no, proceed to Part IV

If yes,

- Has the Claimant been diagnosed with any of the following conditions? Please indicate all that apply and answer questions 1 - 7 for each condition on the following pages. Make an additional copy of pages 16 - 18 for each condition being reported.

○ 01 - Interstitial lung diseases
○ 02 - Chronic respiratory disorder – Fumes/Vapors
○ 03 - Asthma
○ 04 - Reactive airways dysfunction syndrome (RADS)
○ 05 - WTC-exacerbated chronic obstructive pulmonary disease (COPD)
○ 06 - Chronic cough syndrome
○ 07 - Upper airway hyperreactivity
○ 08 - Chronic rhinosinusitis
○ 09 - Chronic nasopharyngitis
○ 10 - Chronic laryngitis
○ 11 - Gastroesophageal reflux disorder (GERD)
○ 12 - Sleep apnea exacerbated by or related to the above conditions.
○ 13 - Low back pain
○ 14 - Carpal tunnel syndrome (CTS)
○ 15 - Other musculoskeletal disorders
○ 16 - Traumatic injury
○ 17 - Other. Please specify

If you are claiming multiple conditions, please use the condition number to indicate for which condition the questions are being answered on the following pages.

Please remember to submit all pages.

Did the Claimant suffer physical harm as a result of one of the air crashes and/or the debris removal? (continued)

Condition Number: ☐☐

Please answer the following questions.

1. When did the Claimant first discover this injury or condition? ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

2. When was the Claimant first treated by a medical professional for this injury or condition? ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

3. When was the Claimant diagnosed with this injury or condition? ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

4. If the Claimant was diagnosed with this injury or condition prior to September 11, 2001, has the condition worsened since September 11, 2001? ○ Yes ○ No ○ NA

5. Has the Claimant been treated for this injury or condition under the WTC Health Program which commenced on July 1, 2011? ○ Yes ○ No

What is the WTC Health Program?

The WTC Health Program, which is operated by the National Institute for Occupational Safety and Health (NIOSH), was established pursuant to Title I of the Zadroga Act and commenced on July 1, 2011. The WTC Health Program provides medical diagnostic and treatment services for eligible individuals with specified injuries or conditions determined to be aggravated, contributed to, or caused by the September 11, 2001 terrorist attacks or the subsequent debris removal efforts. The WTC Health Program includes a nationwide network of health care providers for eligible individuals living outside the New York metropolitan area. As of July 1, 2011, the WTC Health Program assumed the functions and goals of two prior programs: the WTC Medical Monitoring and Treatment Program for responders and recovery and cleanup workers which included a nationwide network of health care providers who provided services for responders living outside the New York metropolitan area, and the WTC Environmental Health Center Community Program for eligible residents, students, and others in the community. Please refer to the Instructions for more information about the WTC Health Program and the two previous programs.

continued on next page

September 11th
Victim Compensation Fund

Claimant's SSN or Nat'l ID # ☐☐☐ - ☐☐ - ☐☐☐☐

Condition Number: ☐☐ Please restate the conditon number being reported on

If, yes,

- At what medical location in the WTC Health Program was the Claimant treated for this injury or condition?
  - ○ Fire Department of New York (FDNY)
  - ○ Long Island Jewish Medical Center
  - ○ Mount Sinai School of Medicine **- Annenberg Building (New York, NY)**
  - ○ Mount Sinai School of Medicine **- Richmond University Medical Center (Staten Island, NY)**
  - ○ Nationwide Network of Health Care Providers Please specify
  - ○ New York University, **Bellevue Hospital Center**
  - ○ State University of New York, Stony Brook **- Suffolk County (Islandia, NY)**
  - ○ State University of New York, Stony Brook **- Nassau County (Garden City, NY)**
  - ○ State University of New York, Stony Brook **- Nassau County (Hicksville, NY)**
  - ○ State University of New York, Stony Brook **- Kings County (Brooklyn, NY)**
  - ○ University of Medicine and Dentistry of New Jersey
  - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Bellevue Hospital Center**
  - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Elmhurst Hospital Center**
  - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Gouverneur Healthcare Services**

6. Was the Claimant treated for this injury or condition prior to July 1, 2011 under the WTC Medical Monitoring and Treatment Program (including a nationwide network of health care providers who provided services for responders living outside of the New York City metropolitan area) or the WTC Environmental Health Center Community Program? ○ Yes ○ No

   If yes,

   - At what medical location was the Claimant treated for this injury or condition?
     - ○ City University of New York/Queens College
     - ○ Fire Department of New York (FDNY)
     - ○ Mount Sinai School of Medicine **- Annenberg Building (New York, NY)**
     - ○ Mount Sinai School of Medicine **- Richmond University Medical Center (Staten Island, NY)**
     - ○ Nationwide Network of Health Care Providers Please specify
     - ○ New York University, **Bellevue Hospital Center**
     - ○ State University of New York, Stony Brook **- Suffolk County (Islandia, NY)**
     - ○ State University of New York, Stony Brook **- Nassau University Medical Center (East Meadow, NY)**
     - ○ State University of New York, Stony Brook **- Nassau County (Hicksville, NY)**
     - ○ University of Medicine and Dentistry of New Jersey
     - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Bellevue Hospital Center**
     - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Elmhurst Hospital Center**
     - ○ World Trade Center Environmental Health Center (NYC Health and Hospitals Corporation) **- Gouverneur Healthcare Services**

Condition Number: ___ Please restate the conditon number being reported on

7. Was the Claimant treated for this injury or condition in another entity/program or by a private physician? ○ Yes ○ No
   - If yes:
     - Please identify the outside physician(s) or other entity/program treating the Claimant for this condition. Include the contact information (name, address, telephone number, email address) of the outside physician or other entity/program.

Physician/Other Entity or Program:

Name

Address

Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

Physician/Other Entity or Program:

Name

Address

Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

If you are asserting additional conditions, please print copies of pages 16 - 18 and complete the questions for each condition asserted. Please remember to submit all pages.

PART IV. ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

A. PRIVACY ACT NOTICE

The Department of Justice is authorized to collect this information by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for and the amount of compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

I Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Signature of Claimant or Authorized Representative (e.g. legal guardian)

Date (mm/dd/yyy) ☐☐ / ☐☐ / ☐☐☐☐

Print Name

Relationship to Claimant

B. PROOF OF DISMISSAL OF ANY LAWSUIT

Have you or any dependent, spouse, or beneficiary of the Claimant filed a lawsuit (or been a party to a lawsuit) in any Federal or State court relating to or arising out of damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (other than a lawsuit to recover collateral source obligations or a lawsuit against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act)?

O Yes O No

- If Yes,

  Was the lawsuit withdrawn or dismissed on or before January 2, 2012? O Yes O No

  Was the lawsuit settled on or before January 2, 2011? O Yes O No

  Was the lawsuit settled in part on or before January 2, 2011?

  O Yes O No O Do not know

  If yes:

  Was the portion of the lawsuit that was not settled on or before January 2, 2011 dismissed on or before January 2, 2012? O Yes O No

Initial here: _____

C. Acknowledgement of Waiver of Rights

I hereby acknowledge that by submission of a substantially complete Eligibility Form, I am **waiving** the right to file a lawsuit (or be a party to a lawsuit) in any federal or state court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal.

Please note this Waiver of Rights could apply to the rights of individuals other than the Claimant. This waiver does not apply to lawsuits to recover collateral source obligations or to a lawsuit against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist attack.

Signature of Claimant or Authorized Representative (e.g. legal guardian)

Date (mm/dd/yyy) __ / __ / ____

If not Claimant:

Print Name

Relationship to Claimant

D. Declaration of Authority to Act on Minor Claimant's Behalf

*Please complete this Section **only** if you completed Part I.B and are submitting this claim on behalf of a minor.*

I hereby declare that the Claimant, _____, is a minor and that I am legally authorized to act on the Claimant's behalf because: (sign one)

(1) I am the Claimant's parent, I have sole legal custody of the Claimant, and the Claimant does not have a legal guardian. I declare under penalty of perjury that the foregoing is true and correct.

Executed on this __ day of _____, 201_.

Signature of Parent

D. Declaration of Authority to Act on Minor Claimant's Behalf (continued)

(2) I am the Claimant's parent, I share legal custody or have joint custody of the Claimant with

_____ , and the Claimant does not have a legal guardian.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____ , 201__ .

Signature of Parent

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____ , 201__ .

Signature of other person with joint legal custody of Claimant

(3) I am the Claimant's legal guardian. I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____ , 201__ .

Signature of Guardian

(4) I am not the Claimant's parent but I have legal custody of the Claimant, the Claimant's parents do not have legal custody of the Claimant, and the Claimant does not have a legal guardian. I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____ , 201__ .

Signature of Authorized Representative

_____

(Relationship to Claimant)

E. AUTHORIZATION OF RELEASE OF INFORMATION

I Authorize the U.S. Department of Justice to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) for the purpose of evaluating my claim for compensation to the VCF from individuals, employers, hospitals, medical service providers, other federal, state or local agencies including the Social Security Administration and the Internal Revenue Service, the World Trade Center Health Program (WTCHP), the National Institute for Occupational Safety and Health (NIOSH), the Clinical Centers of Excellence under the WTCHP, the Nationwide Network of health care providers under the WTCHP, the Fire Department of New York, the New York City Police Department, the New York Office of Payroll Administration, the New York City Employees' Retirement System, the Teachers' Retirement System of the City of New York, the New York City Police Pension Fund, the New York Fire Department Pension Fund, the New York City Board of Education Retirement System, the New York State Workers' Compensation Board, the State of New Jersey Department of Labor and Workforce Development, Division of Workers' Compensation, the State of Connecticut Department of Social Services, Bureau of Rehabilitation Services (formerly the State of Connecticut Workers' Compensation Commission), the Port Authority of New York and New Jersey, the New York City Office of the Chief Medical Examiner, New York City Health and Hospitals Corporation, Child Health Plus, Family Health Plus, Medicaid, the WTC Captive Insurance Company, Inc., the Allocation Neutral for the World Trade Center Litigation Settlement, or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the Claimant whom I represent. The requested medical information may consist of my entire medical records, which may include application or enrollment information, eligibility information, claims records, claim status, patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers. Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the Victim Compensation Fund.

I Recognize that signing this Authorization is voluntary and that my doctors and medical providers and any other entity in possession of my health information may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, the VCF may not be able to evaluate my claim if I do not authorize the release of my medical records.

I Further Recognize that health care providers are required by the Privacy Rule under HIPAA to protect my health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF, DOJ and NIOSH will continue to protect the confidentiality of my medical records to the extent they are permitted to do so under another federal law, the Privacy Act. The VCF will not disclose my identifiable health information that it receives under this Authorization without my written consent except where authorized to do so by law.

I Further Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

I Further Authorize the U.S. Department of Justice to publish the name of the Claimant filing a claim and for whom compensation is sought.

I Further Authorize the release of information relating to my claim, where such information indicates a violation or potential violation of law, including submission of fraudulent claims, to any civil or criminal law enforcement authority or other appropriate agency charged with responsibility of investigating or prosecuting such a violation.

E. AUTHORIZATION OF RELEASE OF INFORMATION (CONTINUED)

I Further Authorize individuals, entities, and federal, state and local agencies including NIOSH and the WTCHP, having information pertinent to my claim to release such information to a duly accredited representative of the Department of Justice during the review of my claim to the Victim Compensation Fund, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that VCF and the entities listed above have already acted based on this Authorization. I understand that to revoke this authorization, I must write to the VCF at September 11th Victim Compensation Fund, P.O. Box 34500, Washington, D.C. 20043. I recognize that this authorization is valid for six (6) years from the date signed or upon my written termination, whichever is sooner.

I Certify that I am the person named below (Claimant to the Victim Compensation Fund or authorized representative of the Claimant) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information _____.

Signature of Claimant or Authorized Representative(s)
(e.g. legal guardian)

__ / __ / ____
Date (mm/dd/yyyy)

Print Name

Relationship to Claimant

F. CLAIMANT'S ACKNOWLEDGMENT OF ATTORNEY'S COMPLIANCE WITH LIMITATION ON ATTORNEY FEES

If the Claimant has been represented by an attorney for services rendered in connection with this claim, the Claimant must sign and date the following acknowledgement:

I hereby acknowledge that I have read and understand the provisions governing the limitation on attorney fees as stated in the Instructions to this claim form, which, in general and with limited exceptions, provide that my attorney, notwithstanding any contract, **cannot charge me more than ten percent (10%) of any award that may be paid on my claim**, and that any expenses incurred by my attorney in connection with my claim, other than those that are routinely incurred, cannot be charged to me unless they have been approved by the Special Master.

Signature of Claimant or Authorized Representative(s)
(e.g. legal guardian)

__ / __ / ____
Date (mm/dd/yyyy)

Print Name

Relationship to Claimant

G. AUTHORIZATION FOR COMMUNICATION AND CORRESPONDENCE

If an attorney or other authorized individual is assisting the Claimant (or authorized representative of the Claimant) with this claim and the Claimant (or authorized representative of the Claimant) wants to authorize the Victim Compensation Fund to communicate with this individual, please sign and date the following authorization.

Indicate here ○ If you would like to receive a copy of all VCF correspondence regarding your claim. Note that if you do ***not*** check this box, the VCF will ***not*** be authorized to contact you directly regarding your claim.

I Authorize the Special Master, the Special Master's designees, the United States Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact my attorney or other persons authorized to act on my behalf (if identified in Part I.C.) if the Special Master needs additional information or clarification about my claim.

Signature of Claimant or Authorized Representative (e.g. legal guardian)

Date (mm/dd/yyyy) __ / __ / ____

If not Claimant:

Print Name

Relationship to Claimant

H. CERTIFICATION OF ACCURACY OF INFORMATION

I hereby certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I agree that any payment made by the VCF is expressly conditioned upon the truthfulness and accuracy of the information and documentation provided in support of the claim. Further, I understand that false statements or claims made in connection with this application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this __ day of _____, 201__.

Signature of Claimant or Authorized Representative (e.g. legal guardian)

If not Claimant:

Print Name

Relationship to Claimant

I. PAPERWORK REDUCTION ACT NOTICE

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. The estimated average time to complete and file this application is 1.5 hours. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1123-0012. (Do not mail your completed application to this address.)

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ - ☐☐ - ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Instructions for Claimant - Please list all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information in Section 1. Please copy this exhibit and complete if you need to list more than four health care providers or other entities. Then, please print your name and address and sign in the block in Section 2.

When you sign this document, you give permission to your doctors, health care providers or other entities listed below to disclose your health information to the September 11th Victim Compensation Fund (VCF), the United States Department of Justice (DOJ), and the National Institute for Occupational Safety and Health (NIOSH) for purposes of evaluating your claim for compensation to the VCF.

Please note that you may revoke this Authorization at any time, except to the extent that VCF and the providers listed below have already acted based on this Authorization. To revoke this authorization, you must write to the providers or entities listed below and to the VCF at the address below. This authorization is valid for six (6) years from the date signed or upon your written termination, whichever is sooner.

Your doctors and medical providers may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization. However, the VCF may not be able to evaluate your claim if you do not authorize the release of your medical records.

Your providers and certain other entities are required by the Privacy Rule under HIPAA to protect your health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF, the DOJ and NIOSH will continue to protect the confidentiality of your medical records to the extent they are permitted to do so under another Federal law, the Privacy Act. The VCF will not disclose your identifiable health information that it receives under this Authorization without your written consent except where authorized to do so by law.

Information to be disclosed to the Victim Compensation Fund includes, but is not limited to, application or enrollment information, eligibility information, claims records, claim status, pension records and files, entire patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to your doctors and medical care providers by other health care providers.

Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the VCF.

I understand that this authorization is voluntary. However, if you refuse to sign this authorization, the VCF will not be able to process your claim for compensation.

OMB 1123-0012

Claimant's SSN or Nat'l ID # ___ - ___ - ____

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information_____.

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the claimant listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities.

Physician/Other Entity or Program:

Doctor/Provider/Entity Name

Doctor/Provider/Entity Address

Doctor/Provider/Entity Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

Physician/Other Entity or Program:

Doctor/Provider/Entity Name

Doctor/Provider/Entity Address

Doctor/Provider/Entity Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the claimant listed below to the VCF, the DOJ and NIOSH:

Section 1 - Name, telephone number and email address for doctors, health care providers or other entities continued.

Physician/Other Entity or Program:

Name

Address

Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

Physician/Other Entity or Program:

Name

Address

Address

Suite Number City

State/Province Zip/Postal Code ( ) - Telephone Number

Email Address

The National Institute for Occupational Safety and Health

September 11th
Victim Compensation Fund

Claimant's SSN or Nat'l ID # ___ - ___ - ____

OMB 1123-0012

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Section 2 - Claimant information and signature.

Claimant's Last Name

First Name

Middle Name

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Social Security or National ID Number

Date of Birth (mm/dd/yyyy)

Telephone Number (Home)

Telephone Number (Work)

Telephone Number (Mobile)

Email Address

This information shall be sent to:

The September 11th Victim Compensation Fund
P.O. Box 34500
Washington, DC 20043

3057384673

September 11th
Victim Compensation Fund

Claimant's SSN or Nat'l ID # ___ - ___ - ____

OMB 1123-0012

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Medical Records

Section 2 - Claimant information and signature continued.

I Certify that I am the person named below (Claimant to the Victim Compensation Fund or authorized representative of the Claimant) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

Signature of Claimant or Authorized Representative(s)

Date (mm/dd/yyyy) __ __ / __ __ / ____

If not Claimant:

Print Name

Relationship to Claimant

Type of coverage to which this authorization applies (the doctor, health care provider or other entity will indicate all that apply)

- ○ Medical
- ○ Disability
- ○ Pharmacy
- ○ Long Term Care
- ○ Other Please specify/describe

6245417649

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ - ☐☐ - ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF PENSION AND HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name		Social Security Number
Patient Address		

I, or my authorized representative, request that pension and health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE OR PENSION INFORMATION WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF PENSION AND HEALTH INFORMATION PURSUANT TO HIPAA

7. Name and address of health provider, pension fund, or other entity to release this information:

- ● New York Office of Payroll Administration (OPA)
  Room 200N
  One Centre Street
  New York, NY 10007
- ○ New York City Police Pension Fund (POLICE)
  233 Broadway, 19th Floor
  New York, NY 10279
- ○ New York Fire Department Pension Fund (FIRE)
  9 MetroTech Center
  Brooklyn, NY 11201
- ○ New York City Employees' Retirement System (NYCERS)
  335 Adams Street, Suite 2300
  Brooklyn, NY 11201-3724
- ○ Teachers' Retirement System of the City of New York (TRS)
  55 Water Street
  New York, NY 10041
- ○ New York City Board of Education Retirement System (BERS)
  65 Court Street, 16th Floor
  Brooklyn, NY 11201-4965

8. Name and address of person(s) or category of person to whom this information will be sent:

The September 11th Victim Compensation Fund of 2001
P.O. Box 34500
Washington, DC 20043

The United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ – ☐☐ – ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Pension Records and Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF PENSION AND HEALTH INFORMATION PURSUANT TO HIPAA

9(a). Specific information to be released:

● Complete Pension File, including, but not limited to: Information regarding the type of pension awarded (ADR, ODR or service), the amount, and whether or not the benefit was awarded pursuant to the WTC Disability Law.

Include: (*Indicate by Initialing*)
_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV Related Information

Authorization to Discuss Health or Pension Information

9(b). ● By initialing here _____, I authorize
(Initials)

_____
(Name of individual health care provider, pension fund or other entity)

to discuss my health or pension-related information with my attorney, or a governmental agency, listed here:

the September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

○ At request of individual

● Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund

11. Date or event on which this authorization will expire:

Six (6) years from the date of signature or upon my written termination

12. If not the claimant, name of person signing form:

_____

13. Authority to sign on behalf of claimant:

_____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of claimant or representative authorized by law

3967206788

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ – ☐☐ – ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

7. Name and address of health provider or other entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

The September 11th Victim Compensation Fund of 2001
P.O. Box 34500
Washington, DC 20043

The United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ - ☐☐ - ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Personal Injury Claimants
Authorization for Release of Health Information by New York Individuals and Entities

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

9(a). Specific information to be released:

○ Medical Record from (insert date) _____ to (insert(date) _____

● Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

○ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV Related Information

Authorization to Discuss Health Information

9(b). ● By initialing here _____ (Initials), I authorize

_____
(Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

the September 11th Victim Compensation Fund and the United States Department of Justice
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	**11.** Date or event on which this authorization will expire:
○ At request of individual ● Other: To evaluate my claim for compensation with the September 11th Victim Compensation Fund	Six (6) years from the date of signature or upon my written termination.
12. If not the patient, name of person signing form:	**13.** Authority to sign on behalf of patient:
_____	_____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

5546235459

September 11th Victim Compensation Fund of 2001
Exhibit C to the Eligibility Form For Personal Injury Claimants
Attorney Certification of Compliance with Provision on Limitation on Attorney Fees (Section 104.81)

If Claimant has been represented by an attorney for services rendered in connection with this claim, **Claimant's attorney must complete the following certification:**

I hereby certify that:

(1) The amount I have charged or will charge for the services I have rendered in connection with this claim, including expenses routinely incurred in the course of providing legal services, is not more than 10 percent of an award that might be paid on this claim; **AND**

(2) I have not charged nor will I charge for any expenses incurred in connection with this claim that are not routinely incurred in the course of providing legal services, unless the Special Master has approved such expenses; **AND**

(3) One of the following statements is true concerning a civil action brought by or on behalf of the Claimant for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (excluding civil actions to recover collateral source obligations or against any person who is a knowing participant in any conspiracy to hijack or commit any terrorist act) that was commenced after December 22, 2003 in which a release of all claims in such action was tendered prior to January 2, 2011:

- ○ I did not charge a legal fee in connection with a settlement of this Claimant's claim(s) in such an action; OR
- ○ I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was 10 percent or more of the aggregate amount of compensation awarded though such settlement, and I have not charged nor will I charge for any services rendered in connection with this claim with the VCF; OR
- ○ I charged a legal fee in connection with a settlement of this Claimant's claim(s) in such an action that was less than 10 percent of the aggregate amount of compensation awarded though such settlement, and the amount I have charged or will charge for the services I have rendered in connection with this claim with the VCF does not exceed the difference between 10 percent of such aggregate amount and the total amount of all legal fees I charged for services rendered in connection with such settlement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____, 201____.

Signature of Attorney

Attorney's Name

Attorney's Firm/Address

Attorney's Firm/Address

1757555432

September 11th
Victim Compensation Fund

OMB 1123-0012

Claimant's SSN or Nat'l ID # ☐☐☐ - ☐☐ - ☐☐☐☐

September 11th Victim Compensation Fund of 2001
Exhibit D to the Eligibility Form For Personal Injury Claimants
Attorney Request for Approval For Charge of Non-Routine Expenses

If the Claimant (or Claimant's authorized representative) is represented by an attorney and the attorney is seeking expenses incurred in connection with the claim other than those that are routinely incurred in the course of providing legal services ("non-routine expenses"), the attorney must request the approval of such expenses by the Special Master. The Special Master will review such requests on a case-by-case basis.

○ Indicate here if you are seeking non-routine expenses in connection with this claim and attach a statement explaining the expenses for which you seek approval and why they should be approved.

Signature of Attorney

☐☐ / ☐☐ / ☐☐☐☐
Date (mm/dd/yyyy)

Attorney's Name

Attorney's Firm/Address

Attorney's Firm/Address

1297328204

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - PERSONAL INJURY CLAIMANTS

In order to process your claim, we need certain supporting documents. This checklist will help you compile those documents. Please categorize your documents by the section of the claim form for which they are being submitted. You are strongly encouraged to upload your documents electronically, which will allow a more efficient claims process. If you are submitting a hard copy claim form and would like to upload documents electronically, you will need to register at www.VCF.gov. Once your hard copy claim form is received, processed, and loaded to the electronic system, you will have the ability to upload documents. If you do not have access to electronic copies of documents or do not wish to register at www.VCF.gov, you may submit hard copies of those documents by mail. To do so, please print this form and on the printed copy, mark the appropriate boxes in the "Mailed" column for each section that you are submitting. Then send the documents along with a copy of this form, by mail to September 11th Victim Compensation Fund; P.O. Box 34500; Washington, DC 20043. The Claimant's Social Security Number or National ID Number should be written on the top of all documents submitted by mail. For your records, you should keep a copy of all documents submitted by mail to the VCF.

Supporting Documentation for Eligibility Form: Parts I-IV	**Mailed**	**Submission Complete**	**For Internal Use Only**
Part I.B. Information about the Claimant's Guardian or Other Authorized Representative (If Applicable) Documentation showing that the Claimant's guardian or other authorized representative has authority to act on behalf of a minor or incapacitated Claimant. Examples include the following: <u>Parent(s) of a Minor Claimant must submit:</u> (1) Claimant's birth certificate; and (2) Court order granting one parent sole custody of Claimant (if applicable) <u>Guardian or Other Person with Legal Custody of a Minor Claimant must submit:</u> (1) Court order granting custody or appointing guardianship; or (2) Will or deed appointing guardianship <u>Guardian of a Non-Minor Claimant must submit:</u> (1) Court order appointing guardianship	○ ○ ○ ○ ○	○	

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Part I.E. Information about the Claimant's Participation in Lawsuits Related to September 11, 2001 (If Applicable)		○	
If the lawsuit has been withdrawn, please submit the notice or motion of withdrawal. That withdrawal must be filed on the relevant court docket on or before January 2, 2012. Please note that you must also submit the final order of the court confirming withdrawal in order for the VCF to issue payment on your claim if you are determined to be eligible.	○		
If the lawsuit has been settled and released, please submit a copy of the settlement agreement and release. The documents you submit must show the date of the settlement and release, the total settlement amount, and the medical condition that was approved for payment under the settlement.	○		
• If the attorney of the Claimant or Claimant's dependent, spouse or beneficiary signed and submitted the release, you must also provide a copy of the retainer agreement with the attorney in the settled lawsuit as proof that the attorney was authorized to sign the release.	○		
If the lawsuit has been dismissed, please submit the order of dismissal.	○		
If you have filed a lawsuit or claim for compensation for the claimed condition with any court or bankruptcy trust for any respiratory injury or disease due to exposure unrelated to September 11, 2001 (e.g., asbestos), please submit information on the action or claim (court/trust, year filed, docket number, injury/disease claimed) and documentation of any judgment, settlement or trust compensation.	○		

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Part II. Information About The Claimant's Presence at a 9/11 Crash Site Between September 11, 2001 and May 30, 2002 Please submit written proof showing the Claimant was present at the site. Examples of acceptable proof include the following: **Responders** Employer records confirming employment with an organization or entity that was responsible for rescue and recovery, clean up, transportation of debris, and confirming that the Claimant was present at the site, including an official personnel roster, site credentials or a pay stub; OR Contemporaneous documentation of presence - such as orders, instructions, confirmation of tasks performed, contemporaneous medical records, or contemporaneous records of federal, state, city or local government. **Presence Claimed Based on Residence** Proof of residence in the area during the relevant time period such as (i) rent receipts, mortgage receipts, or utility bills **and** (ii) proof that the Claimant was physically present at the residence at some point between September 11, 2001 and May 30, 2002, which could include at least two (2) sworn and notarized affidavits (or unsworn statements complying with 28 U.S.C. 1746) from co-habitants, landlords, doormen, or neighbors. **Presence Claimed Based on Non-Responder Work in NYC Exposure Zone or at the Pentagon** Employment records documenting employment **and** presence in the NYC Exposure Zone or at the Pentagon; OR Contemporaneous documentation of presence - such as contemporaneous medical records, or contemporaneous records of federal, state, city or local government. **Presence Claimed Based on School/Care Facility Attendance** School or day care records confirming enrollment / attendance during the period. **Presence in the NYC Exposure Zone in some other capacity (e.g. as a visitor)** Contemporaneous documentation of presence - such as contemporaneous medical records, or contemporaneous records of federal, state, city or local government. **Note:** At least two (2) sworn and notarized affidavits (or unsworn statements complying with 28 U.S.C. 1746) regarding the presence of the Claimant from persons who can attest to the Claimant's presence at a 9/11 crash site will serve as acceptable proof **only if** other official or "primary" forms of proof (such as those listed above) are not available **and** the Fund determines that such affidavits are sufficiently reliable.	○ ○	○	

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - PERSONAL INJURY CLAIMANTS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Part III. Information About the Claimant's Physical Injury For any claimed injuries or conditions that have been certified for treatment under the WTC Health Program after July 1, 2011: • The VCF may be able to obtain the necessary records directly from the WTC Health Program. It is possible that the VCF will need additional records and if so, the VCF will notify you and provide instructions. For any claimed injuries or conditions that have been treated by physicians or programs other than the WTC Health Program: • You will need to provide certified contemporaneous medical records and documents created by or at the direction of the medical professional(s) who provided the medical care. • Your private physician(s) will need to complete certain medical history forms if you are not getting or will not be seeking treatment under the WTC Health Program. The VCF will send the appropriate forms to your physician to complete. Your physician may submit those forms directly to the VCF at September 11th Victim Compensation Fund; P.O. Box 34500; Washington, DC 20043. Once those forms are submitted, you should update this document checklist to confirm submission of those documents. Note: The documentation should include proof of when each injury or condition was first treated by a medical professional.	○	○	
Other Documentation in Support of Eligibility: Parts I-III (optional) Other documentation you have included in support of Parts I-III • Other (please describe)	○		
• Other (please describe)	○		

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - PERSONAL INJURY CLAIMANTS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Part IV. Attestations and Certifications Please print Part IV and Exhibits A-D of the claim form, sign where appropriate, and mail all pages of the Part (including pages you do not need to sign) to the VCF at September 11th Victim Compensation Fund; P.O. Box 34500; Washington, DC 20043. **You must mail pages with your original signature (no copies)**, but you should keep a copy for your own records. If possible, please also upload copies of the signed pages so that the VCF can begin processing your claim.		○	
Part IV.A: Privacy Act Notice Please sign this section. If you are the Claimant's authorized representative (identified in Part I.B), please also print your name and describe your relationship to the Claimant.	○		
Part IV.B: Certification of Dismissal of Lawsuit Please initial in the applicable space	○		
Part IV.C: Acknowledgment of Waiver of Rights Please sign this section. If you are the Claimant's authorized representative (identified in Part I.B), please also print your name and describe your relationship to the Claimant.	○		
Part IV.D: Declaration of Authority to Act on Claimant's Behalf (If Applicable) Only complete this section if you are submitting this claim on behalf of a Claimant under the age of 18.	○		
Part IV.E: Authorization for Release of Information Please sign this section. If you are the Claimant's authorized representative (identified in Part I.B), please also print your name and describe your relationship to the Claimant.	○		
Part IV.F: Claimant's Acknowledgement of Attorney's Compliance with Limitation on Attorney's Fees (If Applicable) Only complete this section if an attorney provided legal services in connection with this claim.	○		
Part IV.G: Authorization for Communication and Correspondence (If Applicable) Only complete this section if an attorney or someone else identified in Part I.C is assisting in the submission of this claim **and** if you want the VCF to communicate with this person about your claim.	○		
Part IV.H: Certification of Accuracy of Information Please sign this section. If you are the Claimant's authorized representative (identified in Part I.B), please also print your name and describe your relationship to the Claimant.	○		

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Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Exhibits A - D		○	
Exhibit A: Authorization for Release of Medical Records Please identify all doctors and health care providers who were involved in diagnosing and treating your injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information relevant to your claim. Then complete your own contact information and sign and date the signature page. If you are the Claimant's authorized representative (identified in Part I.B), please also print your name and describe your relationship to the Claimant.	○		
Exhibit B1: Authorization for Release of Pension Records and Health Information by New York Individuals and Entities (If Applicable) You must complete this exhibit if you have been awarded a pension by one of the following New York pension funds: • New York City Police Pension Fund (POLICE) • New York Fire Department Pension Fund (FIRE) • New York City Employees' Retirement System (NYCERS) • Teachers' Retirement System of the City of New York (TRS) • New York City Board of Education Retirement System (BERS) **To complete this exhibit:** • Complete the boxes at the top of the page • Check the appropriate box in Question #7 • Check the "Other" box in Question #9(a) • In Question #9(b), initial in the appropriate place and write the name of the pension • Complete Question #12 and Question #13 • Sign and date the form	○		
Exhibit B2: Authorization for Release of Health Information by New York Individuals and Entities (If Applicable) You must complete a copy of this exhibit for any medical provider you identified in Exhibit A that is located in New York state. You must also complete a copy of this exhibit for any other doctors, facilities, hospitals, entities or individuals in New York state that have medical information that is relevant to your claim. You should complete a separate copy of this exhibit for each individual and entity. **To complete this exhibit:** • Complete the boxes at the top of the page • Write the name and address of the individual or entity in Question #7 • In Question #9(a), initial in the three spaces next to "Alcohol/Drug Treatment," "Mental HealthInformation" and "HIV-Related Information." • In Question #9(b), initial in the appropriate place and write the name of the individual or entity • Complete Question #12 and Question #13 • Sign and date the form	○		

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - PERSONAL INJURY CLAIMANTS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Exhibits A - D (continued) **Exhibit C: Attorney Certification of Compliance with Provision on Limitation on Attorney's Fees (if Claimant is represented by attorney)** This section must be completed by any attorney that is charging for legal services provided in connection with this claim. If an attorney has not assisted with this claim, you do not need to complete this section. [Attorneys that have provided pro bono assistance with this claim do not need to complete this Exhibit]	○		
Exhibit D: Attorney Request for Approval for Charge of Non-Routine Expenses This section should not be completed unless an attorney that provided legal services in connection with this claim seeks to charge the Claimant (or Claimant's representative) for non-routine expenses. If the attorney seeks non-routine expenses, a statement explaining the non-routine expenses and why they should be approved should be submitted with this Exhibit.	○		