PART I – Victim and Claimant Information

- Victim Information
- Claimant Information
- Personal Representation or Power of Attorney
- Parent or Guardian of a Minor
- Claimant's Attorney
- Alternative Contact

PART II - Eligibility

- Presence
- Prior VCF Claim
- Lawsuit
- Injury/Condition

PART II – Compensation

- Non-economic Loss
- Medical Expenses
- Replacement Services
- Loss of Earnings
- Collateral Source Payments

PART IV- Other Information / Impact Statement

Appendix A - Deceased Victim Information

Appendix B – Private Physician Packet - NYC Exposure Zone

Appendix C - Presence at Pentagon/Shanksville Sites

Appendix D – Checklist

Instructions to Claimant: Please complete the following questions as your claim form submission for compensation from the September 11th Victim Compensation Fund ("VCF"). This form includes both the eligibility and compensation portions of your claim.

Privacy Act Notice:

By submitting this form, you are authorizing the U.S. Department of Justice is 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, and reauthorized by the James Zadroga 9/11 Victim Compensation Fund Reauthorization Act. 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. By this submission, you authorize the U.S. Department of Justice to disclose any records or information relating to your Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of your claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. 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.

Communication with your Attorney or Authorized Representative:

By submitting this form, you are authorizing 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 your attorney or other persons authorized to act on your behalf (if identified in Part I. of this form) if the Special Master needs additional information or clarification about your claim.

If you need assistance completing this form, or have any questions, please call our toll-free Helpline at 1-855-885-1555. For the hearing impaired, please call 1-855-885-1558 (TDD). If you are calling from outside the United States, please call 1-202-514-1100.

PART I - VICTIM AND CLAIMANT INFORMATION

Throughout this claim form, the term "Victim" refers to the individual who has been diagnosed with a September 11th-related physical injury or condition. The term "Claimant" refers to the individual who is filing the claim to seek compensation for the victim. Individuals who are filing a Personal Injury claim on their own behalf are both the claimant and the victim.

INFORMATION ABOUT THE VICTIM

1. Complete the information below for the individual who has been diagnosed with a 9/11-related physical injury.

- Last Name
- First Name
- Middle Name
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Best Telephone Number during business hours (indicate Work, Home, Mobile)
- Alternate Telephone Number(s) (indicate Work, Home, Mobile)
- Social Security Number or Individual Taxpayer Identification Number
- Are you a U.S. citizen? **Yes or No**
    - If no:
        - National Identification Number
        - Country of Citizenship
        - Passport Country (if not U.S.)
        - Passport Number (if not U.S. and available)
- Date of Birth
- Have you ever gone by any other names (e.g., maiden name)? **Yes or No**
    - If yes, please list all former name(s): **First Middle Last**

INFORMATION ABOUT THE CLAIMANT

2. In what capacity are you filing the claim on behalf of the victim? Select one from the list below:

☐ Self – I am the victim. You do not need to complete the information in this section and should continue to Part II – Question 8.

☐ Personal Representative of a deceased individual - complete the Personal Representative/Power of Attorney information below and complete the questions in Appendix A.

☐ Holders of a Power of Attorney – complete the Personal Representative/Holder of a Power of Attorney information below and submit documentation that demonstrates your authority granted under a Power of Attorney.

☐ Parent or Guardian of a minor - complete the Parent/Guardian of a Minor information below and review the information in Appendix D about filing a claim for a victim who is a minor.

☐ Guardian of a non-minor - complete the Guardian of a Non-Minor information below and review the information in Appendix D.

If you are the Claimant and there is someone who you would like to be able to speak on your behalf or find out information about the claim (e.g. a spouse, a child), please provide their contact information in Question 6.

If you are an attorney who is completing this form on your client's behalf, please complete the information below about the Claimant and then provide your information in Question 5.

INFORMATION ABOUT THE PERSONAL REPRESENTATIVE OR HOLDER OF A POWER OF ATTORNEY

3. Please complete the following information about the Personal Representative or Holder of a Power of Attorney:

- Last Name
- First Name
- Middle Name
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Best Telephone Number during business hours
- Social Security Number or Individual Taxpayer Identification Number
- Are you a U.S. citizen? **Yes or No**
    - If no:
        - National Identification Number
        - Country of Citizenship
        - Passport Country (if not U.S.)
        - Passport Number (if not U.S. and available)
- Date of Birth
- Relationship to the Victim

INFORMATION ABOUT THE PARENT OR GUARDIAN OF A MINOR

4. Please complete the following information about the Parent or Guardian of a Minor:

- Last Name
- First Name
- Middle Name
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Best Telephone Number to reach you during business hours
- Social Security Number or Individual Taxpayer Identification Number
- Are you a U.S. citizen? **Yes or No**
    - If no:
        - National Identification Number
        - Country of Citizenship
        - Passport Country (if not U.S.)
        - Passport Number (if not U.S. and available)

5. What is your relationship to the minor victim?
    - Parent
    - Guardian

6. What type of custody do you have of the minor victim?
- I have sole legal custody of the minor
- I share or have joint legal custody of the minor – please also complete the information below for the person with whom you share custody:
    - Last Name
    - First Name
    - Middle Name
    - Mailing Address
    - Mailing Address continued
    - Apartment/Suite Number
    - City
    - State/Province Zip/Postal Code
    - Country (if not the U.S.)
    - Email Address
    - Best Telephone Number during business hours
    - Social Security Number or Individual Tax Payer Identification Number
    - Are you a U.S. citizen? **Yes or No**
        - If no:
            - National Identification Number
            - Country of Citizenship
            - Passport Country (if not U.S.)
            - Passport Number (if not U.S. and available)

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

INFORMATION ABOUT THE GUARDIAN OF A NON-MINOR

7. Please complete the following information about the Guardian of a Non-Minor:

- Last Name
- First Name
- Middle Name
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Best Telephone Number to reach you during business hours
- Social Security Number or Individual Taxpayer Identification Number
- Are you a U.S. citizen? **Yes or No**
    - If no:
        - National Identification Number
        - Country of Citizenship
        - Passport Country (if not U.S.)
        - Passport Number (if not U.S. and available)

- What is your relationship to the non-minor victim?
    - Guardian (please explain):

INFORMATION ABOUT THE CLAIMANT'S ATTORNEY (IF APPLICABLE)

8. If an attorney is assisting you with this claim, please fill out the information below:

- Last Name
- First Name
- Middle Name
- Law Firm or Organization
- Mailing Address
- Mailing Address continued
- Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Telephone Number

INFORMATION ABOUT ALTERNATIVE CONTACT (IF APPLICABLE)

9. If there is someone you would like to be able to speak on the claimant's behalf or find out information about the claim (e.g. a spouse, a child), please list their contact information below. You do not need to list any individual whose information you have already provided as the Personal Representative, parent, guardian, or the claimant's attorney.

- Last Name
- First Name
- Middle Name
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Country (if not the U.S.)
- Email Address
- Best Telephone Number during business hours
- Relationship to Claimant

PART II - ELIGIBILITY TO RECEIVE COMPENSATION

PRESENCE AT A 9/11-RELATED CRASH SITE

To be eligible for compensation from the VCF, the victim must have been present at a designated 9/11-related site between September 11, 2001 and May 30, 2002. If the victim was not present at some point during this timeframe or was not at a designated site, you are not eligible to file a claim for compensation.

In the questions below, the term "responder" is defined as an individual who performed rescue, recovery, demolition, debris cleanup, or other related services at one of the sites 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, the victim may be considered a responder even if he or she performed the listed services through a private employer or on a volunteer basis.

10. On the list below, select the sites at which the victim was present at some point between September 11, 2001 and May 30, 2002.

☐ **New York City ("NYC") Exposure Zone*** – please answer all of the questions below

☐ **Pentagon** - please skip to Question 17 and complete Appendix C

☐ **Shanksville, PA** - please skip to Question 17 and complete Appendix C

If the victim is claiming presence at multiple sites, please complete the appropriate appendices and questions for each site by photocopying and completing the relevant pages and submitting them with your claim form.

**The "NYC Exposure Zone" is defined as "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."*

11. Why was the victim present in the NYC Exposure Zone?

- ☐ Part of the rescue, recovery, and clean-up operations – If this option is selected, was the victim acting in a capacity as a responder? **Yes or No**
- ☐ Through his or her ordinary employment as a non-responder
- ☐ Lived in the NYC Exposure Zone – please skip to Question 15
- ☐ Other – please specify:_____ - please skip to Question 16

12. Please select from the list below the employer or entity for which the victim worked or volunteered at the NYC Exposure Zone between September 11, 2001 and May 30, 2002. If the victim worked or volunteered for more than one entity on the list, you will need to complete this section for each entity by photocopying these pages, completing them for each entity, and then submit them with your claim form.

- ☐ FDNY - please specify the victim's role from the following list:
  - ☐ Active FDNY firefighter or fire officer
  - ☐ Retired FDNY officer
  - ☐ FDNY EMS worker
  - ☐ FDNY engineer, dispatcher, electrician, or other position – please specify:
- ☐ NYPD – please specify the victim's role from the following list:
  - ☐ Police Officer
  - ☐ Other – please specify:
- ☐ Port Authority
- ☐ City of New York (e.g. Department of Sanitation, Transportation)
- ☐ State of New York
- ☐ Consolidated Edison ("ConEd")
- ☐ Cleaning Company (provide name of company):
- ☐ Temporary worker performing clean up (provide name of company):
- ☐ Red Cross
- ☐ Salvation Army
- ☐ Other (provide name of company or organization):

13. Was the victim an employee of the selected entity, a contractor, or a volunteer?

- ☐ Employee
  - Please provide the employer's address, including contact information for any known supervisors/Points of Contact.
  - Please list the victim's dates of employment:

- Is this employer still in business? **Yes or No or Do not Know**

☐ Contractor
- Please provide the name of the victim's employer
- Please provide the employer's address, including contact information for any known supervisors/Points of Contact.
- Please list the victim's dates of employment:
- Is this employer still in business? **Yes or No or Do not Know**

☐ Volunteer

14. If the victim was a member of an employee union when working or volunteering for the selected entity, please identify the union:

15. Select from the list below the location where the victim worked or volunteered for the selected entity while at the NYC Exposure Zone:

☐ On or adjacent to the pile/in the pit

☐ Staten Island/Fresh Kills Landfill

☐ Employer's address as provided in Question X above

☐ Other address within the NYC Exposure Zone – provide the cross streets if known:

16. Please identify the dates (or range of dates) on which the victim worked or volunteered for the selected entity while at the NYC Exposure Zone:

17. Approximately how any hours per day was the victim present on the dates listed above?

18. Did the victim live within the NYC Exposure Zone between September 11, 2001 and May 30, 2002? **Yes or No**

If yes:

- Provide the address where the victim lived:
- Provide the dates on which the victim physically resided within the Zone:

19. Was the victim present within the NYC Exposure Zone in a capacity other than those listed in the questions above? **Yes or No**

If yes:

- Why was the victim present in the NYC Exposure Zone?
  - ☐ Visitor
  - ☐ Other:
- Identify the closest location within the NYC Exposure Zone where the victim was present, including buildings and/or cross streets:
- Identify the dates (or range of dates) on which the victim was present in the NYC Exposure Zone:
- Approximately how any hours per day was the victim present on the dates listed above?

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

20. Did the victim file a claim with the original September 11th Victim Compensation Fund of 2001? **Yes or No or Don't Know**

- If yes, did the victim receive an award from the original September 11th Victim Compensation Fund of 2001? **Yes or No or Don't Know**

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

21. Has the victim or any dependent, spouse or beneficiary filed a lawsuit or been a party to a lawsuit in any court for personal injury damages that resulted from the September 11, 2001 attacks (including damages related to debris removal)? **Yes or No or Don't Know**

- If no, please proceed to the next question.
- If yes:
  - Which lawyer or law firm(s) represented the victim in the lawsuit?
  - Was the lawsuit dismissed or withdrawn? **Yes or No or Don't Know**
    - If yes, on what date was the lawsuit dismissed or withdrawn?
  - Was the lawsuit settled? **Yes or No or Don't Know**
    - If yes:
      - Was it settled with all defendants or only some defendants? **All or Some**
      - On what date was the release signed?

22. Has the victim or any dependent, spouse or beneficiary filed any other claims/lawsuits in relation to the physical conditions claimed here? **Yes or No**

If yes, please provide details of that lawsuit here:

Please review the information in Appendix D about the documentation you must submit to show proper dismissal and/or settlement of your lawsuit.

INFORMATION ABOUT THE VICTIM'S PHYSICAL INJURY

Under the Zadroga Act, only victims who have been diagnosed with a September 11th-related physical injury or condition that is on the WTC Health Program list of presumptive conditions can be eligible for compensation from the VCF. You may not claim compensation for any mental health conditions. Conditions such as PTSD or anxiety are <u>not</u> eligible for compensation from the VCF. If you did not suffer physical harm as a result of the air crashes or debris removal, you are not eligible for compensation.

23. Please complete the table below. When providing dates, you should be as specific as possible. If you do not know the exact date, please provide the month

and year. You will need to submit medical records for each of the conditions listed.

Name of Condition	When did the victim first begin experiencing symptoms?	What was the victim's first date of diagnosis?	When did a physician inform the victim that the condition was a result of 9/11-related exposure?	Is the victim being treated by the WTC Health Program for this condition?

If any condition listed above is not being treated by a physician at the WTC Health Program, please see Appendix B. If the victim is claiming only traumatic injuries or musculoskeletal disorders, please do not complete Appendix B. More information about how to provide documents in support of those injuries can be found at Appendix D.

PART III – COMPENSATION

24. What losses are you seeking through this claim for the victim's 9/11-related physical conditions?

- ☐ Non-economic Loss (i.e. pain and suffering)
- ☐ Medical Expenses
- ☐ Replacement Services
- ☐ Loss of Earnings

If you are claiming non-economic loss only, please continue to Question 31. If you are claiming more than one type of loss, please complete each applicable section below.

MEDICAL EXPENSE LOSS

25. If you are seeking compensation for medical expenses incurred that have not been reimbursed by insurance, Workers' Compensation, or other sources, and are directly related to the treatment of the physical condition(s) listed in Question 20, complete the information below.

- Did the victim have medical insurance at the time of the expense? **Yes or No**
  - If yes, please provide the name of the insurance company:

- Was the victim receiving treatment for these conditions at the WTC Health Program at the time the expenses were incurred? **Yes or No**

Please provide detailed information about all out-of-pocket medical or related expenses on the Medical Expense worksheet and submit proof that each expense has not been reimbursed. The worksheet can be found under "Forms and Resources" on the www.vcf.gov website.

REPLACEMENT SERVICES

Replacement services are household services that the victim provided to the household. Such services include cleaning, cooking, child care, home maintenance and repairs, and financial services, among many others. Replacement services loss is intended to replace something that was lost – that is, something the victim used to do and now cannot do because of a 9/11-related eligible physical injury or condition.

In order to be compensated for replacement services, you must demonstrate that the victim performed the claimed service before the onset of his or her eligible physical injury or condition that now prevents or limits the victim from performing the service.

If you are seeking compensation for replacement services, please complete the table below.

Type of services the victim performed *prior* to the onset of the 9/11-related physical injury or condition	**Time spent per week performing these services *prior* to the onset of the 9/11-related physical injury or condition?**	**When did the victim stop or reduce the amount of time spent per week performing these activities as a result of the 9/11-related physical injury or condition?**	**Which 9/11-related physical injury or condition prevents the victim from performing this activity?**

For information on the documentation that is needed to support a claim for replacement services, please see Appendix D.

LOSS OF EARNINGS

Loss of earnings can be claimed for "past" loss of earnings (i.e. earnings loss as a result of missed work due to a 9/11-related physical injury or condition), as well as loss of future earnings. In the following sections, please indicate what type of loss the victim is seeking.

If you are seeking loss of earnings to date or loss of future earnings, the VCF will consider the victim's employment and compensation history. For Personal Injury claims,

please provide your employment and compensation history for the three years prior to the decrease in earnings caused by your eligible condition. For Deceased claims, please provide the victim's employment and compensation history for the three years prior to the victim's death and, if applicable, for the three years prior to any decrease in the victim's earnings caused by an eligible condition.

26. For which type(s) of earnings are you seeking compensation? *Select all that apply.*

☐ Loss of earnings to date – *Go to Question 24*

☐ Loss of future earnings – *Go to Question 25*

If you are claiming both types of loss of earnings, complete <u>both</u> Questions 24 and 25.

LOSS OF EARNINGS TO DATE

27. For loss of earnings to date, please provide the following information:

- Name of employer(s):
- Describe the specific time periods/dates the victim missed work as a result of the 9/11-related physical injury or condition (i.e. work missed for which the victim was not and will not be compensated):
- Describe the loss of earnings and/or other benefits associated with the time missed from work as a result of the victim's 9/11-related physical injury or condition:

You will need to submit documentation that shows (1) the amount of time the victim missed work, (2) the reduction in earnings or benefits as a result, and (3) the work was missed because of the physical injury or condition sustained as a result of the September 11th air crashes or debris removal. For more information on what is needed, please see Appendix D.

LOSS OF FUTURE EARNINGS

28. Do you seek loss of future earnings due to the victim's physical disability? **Yes or No**

- o If no, continue to Question 31.
- o If yes:
  - Is the disability a result of a 9/11 physical condition/injury? **Yes of No**
  - Is the victim partially or totally disabled? **Partial or Total**
  - Is the disability permanent or temporary? **Permanent or Temporary**
  - Has any government agency, insurer, or physician made a formal determination with respect to the victim's disability? **Yes or No or Do Not Know**
    - If yes, what entity issued the determination (identify all that apply from the list below)? Note: with the exception of NY State Workers'

Compensation, please submit the application and/or decision if you have a copy of it.

- ☐ SSA
- ☐ State Workers' Compensation (identify state):
- ☐ Insurance Company:
- ☐ Physician:
- ☐ Other:
- ☐ FDNY*
  - **I.** Was the victim found to be disabled under the WTC Bill? **Yes or No or Do Not Know**
  - **II.** If yes, was the victim re-classified under the WTC Bill? **Yes or No or Don't Know**
- ☐ NYPD*
- ☐ NYCERS
- ☐ NYSLRS

- If no, what is the status of the application?
  - ☐ Denied
  - ☐ Pending
  - ☐ Do not Know

**For claims filed for FDNY and NYPD victims, please see Appendix D for specific information related to those WTC-related pensions.*

If you are interested in seeking a disability evaluation through the WTC Health Program, please see Appendix D for information about whether the victim may qualify for this process.

29. Complete the information below regarding the victim's employment and compensation history. If the victim had more than one employer, please provide the current or most recent employment information below and attach additional pages if necessary for other employers.

- List the victim's employer at the time the victim became disabled:
- List the dates of employment for this job:
- Is the victim currently working? **Yes or No**
  - If no, date of last day of work:

30. Did the victim receive other types of compensation other than traditional pay, such as the ones listed below?

- ☐ Incentive Pay
- ☐ Bonuses
- ☐ Overtime
- ☐ Tips
- ☐ Longevity
- ☐ Shift Differential
- ☐ Other:

31. Did the victim receive health care benefits through this employer? **Yes or No or Do Not Know**

If the victim received health care benefits, see Appendix D for instructions on what is needed to support this claim.

32. Did the victim's employer offer a pension program? **Yes or No or Do Not Know**
- If yes:
  - Was it a Defined Benefit Plan? **Yes or No or Do Not Know**
    - If yes, is the victim currently receiving a pension? **Yes or No or Do Not Know**
      - If yes, complete the table below.
      - If no, go to Question 30.

Pension Amount ($)	**Frequency (Weekly, Bi-weekly, Monthly, Quarterly)**	**Type of Pension (Regular, Service or Disability)**

Please see the information in Appendix D on the documentation that is needed based on the victim's employer's Defined Benefit Plan.

  - Was it a Defined Contribution Plan, for example, a 401(k) or 403(b)? **Yes or No or Do Not Know**
    - If yes, was the percentage matching contribution higher than 4%? **Yes or No or Do Not Know**
      - If yes, please indicate the percentage:

For information on the documentation that is needed to demonstrate pension loss, please see Appendix D.

33. Did the victim receive any other benefits from this employer? **Yes or No**
- If yes, please identify and submit any documentation of such benefits.

COLLATERAL SOURCE PAYMENTS

You are required to identify any compensation or benefits the victim has received, or is entitled to receive, from other sources with regards to his or her physical injury or condition as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. Under the Air Transportation Safety and System Stabilization Act, Public Law 107-42 (2001), the Special Master is required to reduce the compensation award by the amount of collateral source compensation the victim has received, or is entitled to receive, as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts.

34. Has the victim applied to receive any payments from the Social Security Administration or from workers' compensation programs as a result of the 9/11-

related physical injury or condition? This includes uniformed service benefits similar to Social Security or workers' compensation. **Yes or No or Do Not Know**

- o If yes:
  - Please identify the program(s) or benefit(s) applied for and the status:
  - Are these applications pending? **Yes or No or Do Not Know**
    Please submit a copy of the application submitted.

35. Has the victim received payments from a private disability insurance carrier as a result of the 9/11-related physical injury or condition? **Yes or No or Do Not Know**

- o If yes:
  - Was this coverage held personally or through the victim's employer?
  - Is the victim currently receiving these disability payments?

You will need to provide documents that show the timeline and amount of these payments. Please see Appendix D for instructions.

36. Has the victim received any other payments as compensation for, or in response to, the 9/11-related physical injury or condition (excluding charitable contributions)? **Yes or No or Do Not Know**

- o If yes, please identify and describe below the payments the victim received and submit documentation of such payments.

Additional information on the type of information you should submit can be found in Appendix D.

PART IV- OTHER INFORMATION IN SUPPORT OF APPLICATION

Please use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individual circumstances of your claim and the calculation of the economic and non-economic loss or collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

PAPERWORK REDUCTION ACT NOTICE

This request is in accordance with the Paperwork Reduction Act of 1995. 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. It is estimated that respondents will complete the paper form in an average of 2 hours and the electronic form in an average of 1.5 hours.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-0092.

Appendix A: ADDITIONAL INFORMATION FOR DECEASED CLAIMS

This section is for claimants who are filing a claim on behalf of a deceased individual. This includes decedents who died as a result of their September 11th-related physical injuries or conditions, and those who have died due to other causes.

1. Have you been appointed by a court as the Personal Representative for the deceased individual? **Yes or No**
   - If no, have you attempted to be appointed the Personal Representative by a court? **Yes or No**
     - If yes, please explain in the space below why you were not appointed as the Personal Representative by a court or attach a statement to your claim form with the explanation.

2. Did the Decedent leave a will? **Yes or No or Don't Know**
If yes, please provide a copy of the will.

3. Did the decedent previously file a Personal Injury claim with the re-opened September 11th Victim Compensation Fund? **Yes or No or Don't Know**
If yes, please enter the claim number here, if known: VCF __ __ __ __ __ __ __

4. Did the decedent die as a result of his or her 9/11-related physical injury? **Yes or No or Don't Know**
- If yes, continue to Question 5
- **o** If no, please skip to "Notice to Individuals of Filing of Claim"

INFORMATION ABOUT ADDITIONAL LOSS FOR INDIVIDUALS WHO DIED AS A RESULT OF THEIR 9/11-RELATED PHYSICIAL INJURIES OR CONDITIONS

You may claim additional loss for an individual who died as a result of their 9/11-related physical injuries or conditions. These claims for loss are not applicable for individuals

who did not die as result of their 9/11-related injuries or conditions. If the decedent died of other causes, please do not complete this section.

5. Do you seek compensation for any out-of-pocket burial or memorial service expenses? **Yes or No**
- If yes, list these expenses here, and provide documents showing the expenses:

6. How many people (other than the decedent) were living in the decedent's household at the time of the decedent's death?
Please list each individual who lived in the household in the table below:

Full Name	Date of Birth	Relationship to decedent

7. Were there any individuals who were not living in the household who were receiving substantial financial support from the decedent at the time of death? **Yes or No**
If yes, please list each individual in the table below:

Full Name	Date of Birth	Relationship to decedent	Type and amount of financial support provided

COLLATERAL SOURCE PAYMENTS FOR DECEDENTS' BENEFICIARIES

This section is applicable for individuals who died as a result of their 9/11-related physical injuries or conditions. The questions below apply to the collateral source payments received by the decedent's beneficiaries as a result of his/her death.

Identify any compensation or benefits the decedent's beneficiaries or estate received, or are entitled to receive, from non-VCF sources as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. For example, if the decedent's beneficiaries received insurance or a specific payment from an employer that is not part of the normal compensation, these might be considered "collateral source" payments. Under the statute, the Special Master is required to reduce the compensation award by the amount of collateral source compensation a decedent or a decedent's beneficiaries or estate has received, or are entitled to receive, as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. Note: Settlement payments from September 11th-related lawsuits do not need to be listed again in this section.

8. Have the decedent's beneficiaries received or applied for any benefits from a death benefit program as a result of the decedent's death (other than insurance and

charitable contributions)? Examples of these benefits include Public Safety Officer Benefit payments or Dependency and Indemnity Compensation. **Yes or No or Don't Know**

9. Have the decedent's beneficiaries applied to receive any payments from the Social Security Administration, workers' compensation programs, life insurance payments, or ADD payments as a result of the decedent's death? This includes uniformed service benefits similar to Social Security or workers' compensation. **Yes or No or Don't Know**

If you answered yes to either question above, or if beneficiaries have received any other payments as a result of the decedent's death, other than from charitable contributions, please list them in the table below:

Source of Collateral Death Benefits (e.g. SSA*, Workers' Compensation, Life or ADD Insurance)	**Status of the Application (Granted, Pending, Denied, Do Not Know)**	**Full Name of each beneficiary who has, is, or will be receiving payments**

**For each beneficiary who is receiving SSA survivor benefits, please complete a SSA Authorization. The authorization can be found under "Forms and Resources" on the www.vcf.gov website.*

10. Have the Decedent's beneficiaries received any other payments as a result of the Decedent's death (excluding charitable contributions)? **Yes or No or Don't Know**

- If yes, please explain in the space below:

NOTICE TO INDIVIDUALS OF FILING OF CLAIM

You are required to notify the following people that you are filing a claim on behalf of the decedent:

- ✓ The immediate family of the decedent (including, but not limited to, the spouse, former spouse(s), children, other dependents, siblings, and parents);
- ✓ The executor/administrator and beneficiaries of the decedent's will;
- ✓ The beneficiaries of the decedent's life insurance policies; and,
- ✓ Any other person who may reasonably be expected to assert an interest in an award or to have a cause or action to recover damages relating to the wrongful death of the decedent.

The "Forms and Resources" pages of the VCF website contains the notice you must provide to the required individuals. You are required to provide this notice to everyone in the four categories above, even if they are not included in the decedent's will.

Please complete the information in sections A through G below:

A. Decedent's Parents

Mother:
- Last Name
- First Name

☐ This individual is deceased
☐ I do not know if she is living
☐ This individual is living but I am unable to find her information
☐ This individual is living and her information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

Father:
- Last Name
- First Name

☐ This individual is deceased
☐ I do not know if he is living
☐ This individual is living but I am unable to find his information
☐ This individual is living and his information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

B. Decedent's Spouse or Partner

☐ The decedent did not have a spouse/partner
☐ Decedent's Spouse or Partner:
- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

C. Decedent's Former Spouse

☐ The decedent did not have a spouse
☐ Decedent's former spouse:
  - Last Name
  - First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

D. Decedent's Siblings

Please indicate how many siblings the decedent had, including any siblings who are deceased:

☐ The decedent did not have any siblings

Sibling 1:

- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City

- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

Sibling 2:

- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

E. Decedent's Children and Dependents

Please indicate how many children the decedent had (including biological and adopted children):

☐ The decedent did not have any children

Select the Applicable Relation: Child/Dependent

- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

Select the Applicable Relation: Child/Dependent

- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

G. Other Potential Beneficiaries or Persons of Interest

☐ There are no other potential beneficiaries/persons of interest

Person: Relationship to decedent:

- Last Name
- First Name

☐ This individual is deceased
☐ This individual is living but I am unable to find their information
☐ This individual is living and their information is below:
- Mailing Address
- Mailing Address continued
- Apartment/Suite Number
- City
- State/Province Zip/Postal Code
- Telephone Number
- SSN or National ID Number (if available)

Appendix B: PRIVATE PHYSICIAN PACKET - NYC EXPOSURE ZONE

Assessing Exposure to the September 11, 2001 Attacks -*NYC Disaster Area*

Complete this form if the victim was present in the NYC Disaster Area[1] and is not being treated or has not been treated by a physician at the WTC Health Program.

If the victim is claiming ONLY traumatic injuries or musculoskeletal disorders (i.e. low back pain, carpal tunnel syndrome, etc.) do not complete the form. In order for these conditions to be found eligible, the claimant must show where and when the injury occurred and its relationship to the events of 9/11. Please see Appendix D for more information about what is required for traumatic and musculoskeletal disorders.

1. Victim's Name:
   First Middle Last

2. Dates of response and recovery service for responders. For non-responders, dates the victim was present in the zone (i.e. living, working, or visiting). Please provide dates in MM/DD/YYYY format:
   Start: _____ Finish: _____

   Comments (optional):

3. Was the victim in the NYC disaster area at any time on September 11, 2001?
   - ☐ Yes
   - ☐ No

   If **yes**, check any relevant descriptions below:

   - ☐ Directly in the cloud of dust (or "blackout") from the collapse of the WTC buildings.
   - ☐ Exposed to significant amounts of dust but not directly in the cloud of dust from the collapse of the WTC buildings.
   - ☐ Exposed to some dust but not in the cloud of dust from the collapse of the WTC buildings.
   - ☐ Not exposed to dust and not in the cloud of dust from the collapse of the WTC buildings.
   - ☐ Don't know.

4. If the victim was a first responder, what was the specific location of the victim's response activity ON September 11, 2001?

5. Indicate in the chart below the estimated total duration of exposure for each of the different relevant exposure timeframes.

[1] The NYC disaster area consists of the area of Manhattan that is south of Houston Street; AND any block in Brooklyn that is wholly or partially contained within a 1.5-mile radius of the former World Trade Center site; AND any area related to, or along, routes of debris removal, such as barges and Fresh Kills. See http://www.cdc.gov/wtc/define.html.

"Total Duration of Exposure" is the number of hours that the victim performed rescue, recovery, demolition, debris removal, and related support services ("Response Activities") or lived, worked, went to school, commuted or visited ("Non-Response Activities") while within the NYC disaster area.

Relevant Exposure Timeframes	**Estimated Total Duration of Exposure**	**Location Where Activities were Performed**
September 11 – 14, 2001		
September 15 – 30, 2001		
October 1, 2001 – July 31, 2002		

6. If the victim performed response activities as described in question 3, indicate in the charts below the location(s) where the victim performed the response activities and the jobs/tasks performed by the victim.

- Location of response activities: (please check all that apply)
  - ☐ On the pile/in the pit
  - ☐ Adjacent to the pile/pit
  - ☐ Landfill
  - ☐ Barges/loading piers
  - ☐ Elsewhere south of Canal Street
  - ☐ Other location:
  - ☐ Don't Know

- Job/task: (please check all that apply)
  - ☐ Body bag work
  - ☐ Bucket brigade
  - ☐ Cable installation/repair/ splicing (excluding work performed in manholes)
  - ☐ Cable installation/repair/ splicing (including work performed in manholes)
  - ☐ Canteen services
  - ☐ Counselor
  - ☐ Custodian
  - ☐ Dog Handler
  - ☐ Dust suppression
  - ☐ EMT
  - ☐ Escorting
  - ☐ Fire Fighter
  - ☐ Excavation/confined space work
  - ☐ Industrial hygiene
  - ☐ Morgue work
  - ☐ Perimeter security
  - ☐ Sanitation worker
  - ☐ Search and rescue
  - ☐ Sifting (excluding conveyor belt)
  - ☐ Sifting (including conveyor belt)
  - ☐ Towing
  - ☐ Truck loading/unloading
  - ☐ Truck routing
  - ☐ Torch cutting or burning
  - ☐ Work with concrete
  - ☐ Other; Specify:

7. If the victim's activities were not as a responder, indicate below the location(s) where the victim lived, worked, went to school, commuted or visited the NYC disaster area. Please select all that apply.
   - ☐ Worker in one of the WTC towers
   - ☐ Worker in surrounding offices, stores, restaurants, or other workplace
   - ☐ Patron of surrounding stores, offices, or restaurants
   - ☐ Student or staff at school or preschool
   - ☐ Adult in daycare or staff at a daycare center
   - ☐ In transit; Describe:
   - ☐ At place of residence; Provide address:
   - ☐ Other location; Specify:

8. In the table below, indicate the victim's relative amount of dust/fume/smoke exposure while performing the jobs/tasks/activities described above for each time period listed. Please check the appropriate box(es) in the table.

Time Period during which Jobs/Tasks were Performed	**Heavy visible layer of dust and/or smell of WTC smoke**	**Light visible layer of dust and/or smell of WTC smoke**	**No visible layer of dust and/or smell of WTC Smoke**
September 11-14, 2001	☐	☐	☐
September 15-30, 2001	☐	☐	☐
October 1, 2001- July 31, 2002	☐	☐	☐

APPENDIX C: PRESENCE AT THE PENTAGON AND SHANKSVILLE, PA SITES

1. On the list below, select the sites at which the victim was present at some point between September 11, 2001 and May 30, 2002.

   ☐ Pentagon, Arlington, VA

   ☐ Shanksville, PA

2. Why was the victim present at the site?
   - ☐ Part of the rescue, recovery, and clean-up operations – if this option is selected, was the victim acting in a capacity as a first responder? **Yes or No**
   - ☐ Through his or her ordinary employment
   - ☐ Other – please specify:_____ Please go to Question 7

3. Was the victim an employee of the selected entity, a contractor, or a volunteer?

   ☐ Employee
   - o Please provide the employer's address, including contact information for any known supervisors/Points of Contact.
   - o Please list the victim's dates of employment:
   - o Is this employer still in business? **Yes or No or Do not Know**

   ☐ Contractor
   - o Please provide the name of the victim's employer
   - o Please provide the employer's address, including contact information for any known supervisors/Points of Contact.
   - o Please list the victim's dates of employment:
   - o Is this employer still in business? **Yes or No or Do not Know**

   ☐ Volunteer

4. If the victim was a member of an employee union when working or volunteering for the selected entity, please identify the union:

5. Please identify the dates (or range of dates) on which the victim worked or volunteered for the selected entity:

6. Approximately how any hours per day was the victim present on the dates listed above?

7. Was the victim present in a capacity other than those listed in the questions above? **Yes or No**

   If yes, please explain what the victim was doing at the site:

**********END OF FORM**********