September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

SEPTEMBER 11TH VICTIM COMPENSATION FUND ELIGIBILITY FORM FOR DECEASED INDIVIDUALS

Eligibility Form (Parts I- IV)

PART I. INFORMATION ABOUT THE CLAIM AND DECEDENT

A. GENERAL INFORMATION ABOUT THE DECEDENT (AS OF THE TIME OF DEATH)

Decedent's Last Name

First Name

Middle Name

Mailing Address

Mailing Address

Apartment/Suite Number

City

State/Province

Zip/Postal Code

Country

Date of Birth (mm/dd/yyyy) / /

Date of Death (mm/dd/yyyy) / /

Country of Citizenship

Social Security or National ID Number - -

Passport Country (if not U.S.)

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

Marital status at time of death:

- ○ Married
- ○ Widowed
- ○ Separated
- ○ Divorced
- ○ Single
- ○ Other. Please explain:

6837529033

B. INFORMATION ABOUT THE DECEDENT'S PERSONAL REPRESENTATIVE

The Personal Representative is the only person who can submit a claim to the Victim Compensation Fund for a Decedent. To be a Personal Representative, you generally must be appointed by a court as (a) the Personal Representative, (b) the Executor of the Decedent's will, or (c) the Administrator of the estate. In some limited instances, where a court has not made such an appointment and such issue is **not** the subject of a pending dispute, the Special Master may appoint a Personal Representative for the Fund.

○ I have been appointed by a court as (a) the Personal Representative, (b) the Executor of the Decedent's will or (c) the Administrator of the Decedent's estate. (Please submit original court order or Letter of Administration)

○ I understand that in most cases the Personal Representative should be the individual already appointed by a court, but I have been unable to be appointed Personal Representative, Executor or Administrator by a court and hereby request that the Special Master appoint me as Personal Representative for this fund.

Please describe below why you have been unable to be appointed as Personal Representative. Also, please submit a certified copy of the Decedent's will (if one exists) showing you are named the executor, as well as relevant filings. If no will exists, submit (a) relevant proof of your relationship to the Decedent and (b) proof that you are the first person in line of succession under the laws of intestacy in the Decedent's domicile:

Explanation

Explanation

Explanation

Are you aware of anyone else who has been named Executor of the Decedent's will or who has been appointed or has applied to be appointed as (a) the Personal Representative, (b) the Executor of the Decedent's will, or (c) the Administrator of the Decedent's estate? Yes ○ No ○

If yes, please explain

Explanation

Explanation

Explanation

Personal Representative's Last Name

First Name

Middle Name

Social Security or National ID Number

2313556780

B. INFORMATION ABOUT THE DECEDENT'S PERSONAL REPRESENTATIVE (continued)

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

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

Passport Country (if not U.S.)

○ 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.

C. Information About the Personal Representative's Attorney or Alternate Contact Person (If Applicable)

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

○ Attorney

○ Other Individual

Title:

Relationship to Personal Representative:

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 Personal Representative should indicate here and complete the certification at Part IV.F (Authorization of Attorney Communication and Correspondence) if the Personal Representative authorizes the VCF to communicate with this individual about his/her claim. The Personal Representative 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 Decedent's Prior Claim with the September 11th Victim Compensation Fund (if applicable)

Was a claim previously filed by or on behalf of the Decendent with the original September 11th Victim Compensation Fund of 2001? ○ Yes ○ No ○ Do not know

If no, please proceed to Part I.E

If yes,

- What injury/injuries did the Decedent allege in connection with the prior claim? Please identify.

- Was a payment issued on the claim? ○ Yes ○ No ○ Do Not Know

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

  If yes,

  - What was the basis for the ineligibility determination?

    ○ Outside the original Victim Compensation Fund zone

    ○ Did not sustain physical harm

    ○ Did not sustain physical harm within requisite timeframe

    ○ Do not know.

    ○ Other reason for ineligibility. Please specify.

  - For what injury/injuries was the Decedent previously compensated?

    ○ Traumatic injury. Please specify.

    ○ Respiratory or other latent injury. Please specify.

    ○ Other.

    ○ Do not know.

  - Was the Decedent compensated for any disability or future lost wages?

    ○ Yes ○ No ○ Do Not Know

    If yes, was it for a:

    ○ Permanent disability

    ○ Temporary disability

E. Information About the Decedent's Participation in Lawsuits Related to September 11, 2001 (if applicable)

1. Has the Decedent or any dependent, spouse or beneficiary of the Decedent 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.) ○ Yes ○ No

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

If yes,

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

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

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

Has the lawsuit been settled? ○ Yes ○ No

If yes,

Did the individual settle all claims? ○ Yes ○ 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? ○ Yes ○ No

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

- If yes,

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

○ Decedent

○ Decedent's attorney

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

2. Has the Decedent filed or has any dependent, spouse or beneficiary of the Decedent filed on the Decedent'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: ○

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

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

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

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

PART II. INFORMATION ABOUT THE DECEDENT'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 Decedent's presence at a 9/11 crash site from September 11, 2001 through May 30, 2002

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

If you are submitting a hard copy claim form please make copies of this Part II of the claim form and submit multiple copies of this Part II.

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, a Decedent may be considered a Responder even if the Decedent 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 Decedent was a Responder within the NYC Exposure Zone

Please indicate the organization(s) for which the Decedent 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

1638226053

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

Please identify the Decedent'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 Decedent was a Responder at the Pentagon

Please identify the organization(s) for which the Decedent 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 Decedent was present during the period beginning September 11, 2001 through May 30, 2002

Address

Address

9924259482

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

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

Please identify the organization(s) for which the Decedent 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 Shanksville site where the Decedent was present during the period beginning September 11, 2001 through May 30, 2002

Address

Address

4. If the Personal Representative claims the Decedent's presence at the site based on residence within the NYC Exposure Zone

Please identify the address of the Decedent'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 Decedent 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 Decedent's employer for the period beginning September 11, 2001 through May 30, 2002 during which you are asserting Decedent's presence in the NYC Exposure Zone. If the Decedent 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 Decedent worked.
Please complete this Part separately for each location.

Address

Address

6. If the Decedent 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 Decedent's employer for the period beginning September 11, 2001 through May 30, 2002 during which you are asserting Decedent's presence in the NYC Exposure Zone. If the Decedent 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 Decedent worked (if not same as above).
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 Decedent 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 Decedent 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 Decedent was present within the NYC Exposure Zone in some other capacity (e.g., as a visitor).

Please describe why the Decedent 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 Decedent 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 Decedent was present at the Pentagon site (as non-Responder).

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

- ○ Worked at Pentagon
- ○ Attended meeting at Pentagon
- ○ Other. Please explain

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

Employer Name

Employer's Address

Employer's Address

( ) -
Telephone Number

Email Address

Identify the location at the Pentagon site where the Decedent 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 presence at the site is asserted at the location(s) indentified in Part II.A (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 Decedent was present at a 9/11 crash site.

PART III. INFORMATION ABOUT THE DECEDENT'S DEATH

Was the Decedent's death a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts that took place in the immediate aftermath of those crashes? ○ Yes ○ No

If no, proceed to Part IV

If yes,

- Was the Decedent's death a result of one 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
○ Primary cause ○ Contributing cause

○ 02 - Chronic respiratory disorder – Fumes/Vapors
○ Primary cause ○ Contributing cause

○ 03 - Asthma
○ Primary cause ○ Contributing cause

○ 04 - Reactive airways dysfunction syndrome (RADS)
○ Primary cause ○ Contributing cause

○ 05 - WTC-exacerbated chronic obstructive pulmonary disease (COPD)
○ Primary cause ○ Contributing cause

○ 06 - Chronic cough syndrome
○ Primary cause ○ Contributing cause

○ 07 - Upper airway hyperreactivity
○ Primary cause ○ Contributing cause

○ 08 - Chronic rhinosinusitis
○ Primary cause ○ Contributing cause

○ 09 - Chronic nasopharyngitis
○ Primary cause ○ Contributing cause

○ 10 - Chronic laryngitis
○ Primary cause ○ Contributing cause

○ 11 - Gastroesophageal reflux disorder (GERD)
○ Primary cause ○ Contributing cause

○ 12 - Sleep apnea exacerbated by or related to the above conditions.
○ Primary cause ○ Contributing cause

○ 13 - Other musculoskeletal disorders
○ Primary cause ○ Contributing cause

○ 14 - Traumatic injury
○ Primary cause ○ Contributing cause

○ 15 - Other. If other, please identify and explain how the death was a result of the 9/11 crashes.

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.

Was the Decedent's death a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts that took place in the immediate aftermath of those crashes? (continued)

Condition Number: ☐☐

Please answer the following questions.

1. When did the Decedent first discover this injury or condition? __ / __ / ____ (mm/dd/yyyy)

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

3. When was the Decedent diagnosed with this injury or condition? __ / __ / ____ (mm/dd/yyyy)

4. Was the Decedent 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

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

If, yes,

- At what medical location in the WTC Health Program was the Decedent 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**

5. Was the Decedent 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 Decedent 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

6. Was the Decedent treated for this injury or condition by another entity/program or by a private physician? ○ Yes ○ No

- If yes:
  - Please identify the outside physician(s) or other entity/program treating the Decedent 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

7. Please submit Decedent's death certificate and any other medical documents showing Decedent's cause of death. You may also need to submit the Decedent's certified medical records related to this injury or condition. Please see the Instructions and the Document Checklist for more information.

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 Personal Representative

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

Print Name

B. Proof of Dismissal of any Lawsuit

Have you or any dependent, spouse, or beneficiary of the Decedent 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 Personal Representative. 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 Personal Representative

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

Print Name

D. 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 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 Decedent whom I represent. The requested medical information may consist of the Decedent's 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.

D. AUTHORIZATION OF RELEASE OF INFORMATION (CONTINUED)

I Recognize that signing this Authorization is voluntary and that the Decedent's doctors and medical providers and any other entity in possession of Decedent's 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 the Decedent's medical records.

I Further Recognize that health care providers are required by the Privacy Rule under HIPAA to protect the Decedent's 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 the Decedent's medical records to the extent they are permitted to do so under another federal law, the Privacy Act. The VCF will not disclose the Decedent's 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 Personal Representative filing a claim and the name of the Decedent 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.

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 (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) 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 Personal Representative

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

Print Name

1775199346

E. Personal Representative's Acknowledgment of Attorney's Compliance with Limitation on Attorney Fees

If an attorney has rendered services in connection with this claim, the Personal Representative 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 Personal Representative

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

Print Name

F. Authorization for Attorney Communication and Correspondence

If an attorney or other authorized individual is assisting the Personal Representative with this claim and the Personal Representative 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 this claim. Note that if you do not check this box, the VCF will **not** be authorized to contact you directly regarding this 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 Personal Representative

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

Print Name

G. 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 Personal Representative

Print Name

H. 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

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

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

Instructions for Personal Representative - 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 the Decedent's 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.

The Decedent's 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.

7987305975

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit A to the Eligibility Form For Deceased Individuals
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 Decedent 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

2470624588

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

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

I hereby authorize the person, carrier or other entity listed below to disclose confidential information about the Decedent 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

9809594307

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'ID #

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

Section 2. - Decedent information

Decedent's Last Name

Decedent's Date of Birth __ / __ / ____

First Name

Middle Name

Decedent's SSN or Nat'l Id # ___ - __ - ____

Address

Address

City

State/Province

Zip/Postal Code

Section 3. - Personal Representative Information and Signature

This information shall be sent to:

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

I Certify that I am the person named below (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) 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.

Personal Representative Signature

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

6760265428

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

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

Section 3. - Personal Representative Information and Signature (continued)

Personal representative's Last Name

Date of Birth __ / __ / ____

First Name

Middle Name

SSN or Nat'l Id # ___ - __ - ____

Address

Address

City

State/Province

Zip/Postal Code

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

4111546361

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Deceased Individuals
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	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 the 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. The Decedent's 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).

6750649030

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Deceased Individuals
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

6148342963

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B1 to the Eligibility Form For Deceased Individuals
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

* **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.**

8055389042

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Deceased Individuals
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).

9325070512

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Deceased Individuals
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

9639082524

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit B2 to the Eligibility Form For Deceased Individuals
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.**

8022202433

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

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

If the Personal Representative has been represented by an attorney for services rendered in connection with this claim, **Personal Representative'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 Decedent 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 Decdent's claim(s) in such an action; OR
- ○ I charged a legal fee in connection with a settlement of this Decedent'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 Decdent'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

6447251414

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

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

If the Personal 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

7915042312

September 11th
Victim Compensation Fund

September 11th Victim Compensation Fund of 2001
Exhibit E to Eligibility Form For Deceased Individuals
Notice of Filing Claim

Instructions to Decedent's Personal Representative:

- Fill out a separate copy of this page for each person to whom you are required to provide a Notice of Filing.
- On each copy, fill out the name and address of the person to whom you are providing the Notice and insert the name of the Decedent in the spaces provided below as indicated.
- Deliver each Notice personally or by certified mail, return receipt requested.
- *You must deliver a copy of this document to the following people:*
  - The immediate family of the Decedent (including, but not limited to, the spouse, former spouse(s), children other dependents, siblings, and parents)
  - The Executor or Administrator and beneficiaries of the Decedent's will and life insurance policies.
  - 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.

TO: NAME: _____

ADDRESS: _____

_____

_____

You are receiving this notice to inform you that a claim on behalf of _____ (insert name of Decedent) is being filed with the September 11th Victim Compensation Fund of 2001. The claim is being filed by _____ (insert name of Personal Representative).

The rules that govern the Victim Compensation Fund state that only **one** claim may be filed in connection with the death of a Decedent and that the claim must be filed by the Decedent's Personal Representative. The rules also state that any award from the Victim Compensation Fund shall be paid to the Personal Representative and that the Personal Representative is required to distribute the award among the Decedent's beneficiaries in accordance with the laws of the Decedent's domicile.

You have been notified that a claim is being filed on behalf of _____ (insert name of Decedent) because the Personal Representative is required to give notice of claim filing to the Decedent's immediate family, to the executor, administrator, and beneficiaries of the Decedent's will and life insurance policies and to other people who might reasonably have an interest in any award that may be made from the Victim Compensation Fund.

The rules that govern the filing of claims with the Victim Compensation Fund require the Personal Representative waive any right to file a lawsuit for damages sustained as a result of the terrorist-related aircraft crashes on September 11, 2001 or debris removal. This waiver could affect the rights of others, including you, to file any such lawsuits.

You are not required to take any action in response to this notice. However, any objection to the filing of the claim must be made within 30 days after the claim has been filed, which could be a soon as 30 days from the date this notice was mailed or otherwise provided to you.

If you want to learn more about the Victim Compensation Fund, please call 1-855-885-1555; TDD:1-855-885-1558; outside the U.S.: 1-212-619-3215. Information can also be obtained over the internet at www.vcf.gov

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit F - List of Individuals Notified of Claim Filing

I hereby certify that I have provided the required Notice of Filing of Claim to all the individuals listed below by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided.

Signature of Personal Representative

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

Relationship to Decedent

Mother:

Last Name

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

First Name

Middle Name

___ - __ - ____
SSN or Nat'l ID # (if available)

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Father:

Last Name

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

First Name

Middle Name

___ - __ - ____
SSN or Nat'l ID # (if available)

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

4449067284

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit F - List of Individuals Notified of Claim Filing

Spouse:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Former Spouse:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Sibling:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

0266394280

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit F - List of Individuals Notified of Claim Filing

Sibling:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Child:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Child:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

4349031318

September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

September 11th Victim Compensation Fund of 2001
Exhibit F - List of Individuals Notified of Claim Filing

Child:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Partner:

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

Other:

Please describe

Last Name

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

First Name

Middle Name

SSN or Nat'l ID # (if available) ___ - __ - ____

Mailing Address

Mailing Address

(___) ___ - ____
Telephone Number

◯ Hand Delivered

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

◯ Certified Mail Return Receipt Requested

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

◯ Indicate here if you need more space for Exhibit F and are submitting additional pages.

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September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

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 Decedent's Social Security Number or National ID Number and the Personal Representative'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 Decedent's Personal Representative		○	
Documentation showing that the Personal Representative has authority to act on behalf of the Decedent:			
Original Court Order or Letter of Administration showing your appointment as (1) Personal Representative, (2) Executor of Will, or (3) Administrator of Estate. Note: You must mail original Order or Letter of Administration.	○		
OR			
If you were unable to obtain an appointment as one of the above, any documentation demonstrating that you could not get the necessary appointment (see instructions for more information) and either:	○		
1) Submit a copy of the Decedent's **will** and copies of relevant filings you have made to probate the will	○		
OR			
2) If there is no will, submit:			
• Proof of your relationship to the Decedent (such as birth certificate(s) and/or marriage certificate) and	○		
• Proof that you are the first person in line of succession under the laws of intestacy in the Decedent's domicile.	○		

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September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Part I.E. Information about the Decedent'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 Decedent or Decedent'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 Decedent or anyone on the Decedent's behalf has 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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September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Part II. Information About The Decedent's Presence at a 9/11 Crash Site Between September 11, 2001 and May 30, 2002		○	
Please submit written proof showing the Decedent 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 Decedent 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 Decedent 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 Decedent from persons who can attest to the Decedent'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.	○		

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September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Part III. Information About the Decedent's Death		○	
Proof of death (e.g. original or certified copy of death certificate) and any other documents showing Decedent's cause of death	○		
AND			
For any claimed injuries or conditions that were 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 were 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. • Decedent's private physician(s) will need to complete certain medical history forms. The VCF will send the appropriate forms to the physician(s) to complete. The Decedent's 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)	○		

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September 11th
Victim Compensation Fund

OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

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-F 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 electronic copies of the signed pages. This will allow the VCF to begin processing your claim.		○	
Part IV.A: Privacy Act Notice Please sign this section.	○		
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.	○		
Part IV.D: Authorization for Release of Information Please sign this section.	○		
Part IV.E: Personal Representative'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.F: 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.G: Certification of Accuracy of Information Please sign this section.	○		
Exhibits A - F		○	
Exhibit A: Authorization for Release of Medical Records Please identify all doctors and health care providers who were involved in diagnosing and treating the Decedent's injury, as well as any other entities (e.g., insurance companies, workers' compensation programs, pension programs) that may have medical information relevant to this claim. Then complete your own contact information and sign and date the signature page.	○		

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OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Exhibits A-F (continued)			
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 the Decedent was 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 Health • Information" 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	○		

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OMB 1123-0012

Decedent's SSN or Nat'l ID # ___ - __ - ____

___ - __ - ____
Personal Representative's SSN or Nat'l ID #

ELIGIBILITY FORM SUPPORTING DOCUMENTATION CHECKLIST - DECEASED INDIVIDUALS

Supporting Documentation for Eligibility Form: Parts I-IV	Mailed	Submission Complete	For Internal Use Only
Exhibits A-F (continued)			
Exhibit C: Attorney Certification of Compliance with Provision on Limitation on Attorney's Fees (if Decedent or Personal Representative 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 Decedent or Personal 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.	○		
Exhibit E: Notice of Filing Claim You must complete and send a copy of this exhibit to all of the following: • The immediate family of the Decedent (including, but not limited to, the spouse, former spouse(s), children other, depenpendents, siblings, and parents). • The Executor or Administrator and beneficiaries of the Decedent's will and life insurance policies. • 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.			
Exhibit F: Notice of Filing Claim You must complete this exhibit to identify for the VCF all individuals to which you have sent a copy of Exhibit E.	○		

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