IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

IN RE: PHILIPS RECALLED CPAP, BI-LEVEL PAP, AND MECHANICAL VENTILATOR PRODUCTS LIABILITY LITIGATION	)	Case No. 2:21-mc-01230-JFC
	)	MDL No. 3014
THIS DOCUMENT RELATES TO:	)	
	)	Honorable Joy Flowers Conti
Personal Injury Cases Brought By Litigating Plaintiffs	)	

LITIGATING PLAINTIFF FACT SHEET

This Litigating Plaintiff Fact Sheet ("PFS") must be completed by all Litigating Plaintiffs, as defined by Docket Management Order at ECF No. 2769. ***Please answer every question truthfully and accurately to the best of your knowledge.***

1. You must answer every question and provide all requested materials in this PFS. It is not sufficient to answer a question by saying "see medical records"; you must complete this form by providing a response to each question.

2. If you have previously submitted a version of this PFS prior to the Court's Docket Management Order at ECF No. 2769, such submission ***does not satisfy*** your PFS requirement under the Order. You must answer every question and provide all requested materials as detailed in ***this*** PFS, which seeks additional information specific to Litigating Plaintiffs.

3. Please consult with your lawyer if you need any assistance.

4. ***Please do not leave any questions unanswered***; if a question does not apply, then please respond with "N/A". The PFS will be considered deficient and will require supplementation in accordance with the deficiency process set forth in Docket Management Order at ECF No. 2769 if questions are left unanswered.

5. By signing the declaration at the end of this document, you are making your responses ***under oath and under penalty of perjury*** as if you were testifying in court.

6. You must supplement your responses if you learn that they are incomplete or incorrect, or if your circumstances have changed, in any material respect.

7. For each question where the space provided does not allow for a complete answer**,** please attach additional sheets so that you can provide complete answers. When attaching additional sheets, clearly label to which question your answer pertains and upload and produce the additional sheets via MDL Centrality.

8. You must authorize the disclosure of your personal records (including medical information protected by HIPAA, 45 CFR 164.508) for the purpose of review and evaluation in connection with your claim. For each health care provider, physician, pharmacy, retailer, and government agency identified in your responses to the PFS, please provide completed and signed (***but undated***) authorizations attached as Exhibit C as described in part VI below. You may not provide a blank authorization form. All authorizations must be completed to include the addressee.

9. Definitions:

   - "**Health Care Provider**" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric, or psychological care or advice, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care, and/or treatment of the plaintiff or plaintiff's decedent.

   - "**Durable medical equipment**" ("DME") means any equipment or supplies ordered by a healthcare provider for a patient due to a medical condition or illness.

   - **"Respironics Device"** means any Continuous Positive Airway Pressure device, Bi-Level Positive Airway device, or mechanical ventilator device manufactured by Philips RS North America LLC that you acquired or used at any time.

   - "**Other Device**" means any Continuous Positive Airway Pressure device, Bi-Level Positive Airway device, or mechanical ventilator device that you acquired or used at any time, other than a Respironics Device.

Information provided in response to this PFS, including any response to any authorizations, will only be used for purposes related to this litigation, and shall be deemed

Confidential pursuant to the Amended Stipulated Protective Order (ECF No. 765). A completed PFS shall be considered discovery responses pursuant to Fed. R. Civ. P. 33 and 34 and will be governed by the standards applicable to written discovery under the Federal Rules of Civil Procedure.

I. GENERAL INFORMATION

1. Legal name of person completing this PFS (first, middle, last):

2. Legal name of person or entity on whose behalf a claim is being made (if different from the person identified in response to question 1) (first, middle, last):

3. Legal name of person who uses or used the Respironics Device(s) (if different from the person identified in response to question 2) (first, middle, last):

4. Previous or Additional Names used by person who uses/used the Respironics Device(s):

5. Identify each person that you believe has knowledge or information regarding the facts, circumstances, injuries, conditions, damages, or allegations contained in your Complaint.

6. If you are completing this PFS in a representative capacity (*e.g.*, on behalf of the estate of a deceased person or on behalf of a minor), please complete the following information about yourself and the person on whose behalf you are completing the PFS (the "Represented Person"):

Your Address	**Represented Person's Address (Respironics Device User/Plaintiff's Last Known Address)**	**Capacity in which you are representing the individual or estate**	**Relationship to the Represented Person (Respironics Device User/Plaintiff)**

   a. If you represent a decedent's estate complete the following:

      Date of death:

      State of death:

7. Case Information:

   This PFS pertains to the following case:

Case Name:	
Case Number:	

The rest of this PFS requests information about the person <u>who used the Respironics Device(s)</u>. If you are completing this form in a representative capacity, please respond to the remaining questions with information about the person who used the Respironics Device(s). Whether you are completing this PFS for yourself or for someone else, "you" means the person who used the Respironics Device.

II. RESPIRONICS DEVICE USAGE

COMPLETE THE QUESTIONS IN THIS SECTION FOR EACH RESPIRONICS DEVICE. (ATTACH SEPARATE SHEETS AS NECESSARY FOR ADDITIONAL DEVICES.)

8. Please complete the following chart for each Respironics Device. For each Health Care Provider and DME identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Respironics Device Model Name and Number	Respironics Device Serial Number	Approximate Purchase Date of Respironics Device	How much of the total purchase price of the Respironics Device did you pay?	Reason for Use of the Respironics Device	Name and Address of Health Care Provider(s) who prescribed/recommended the use of the Respironics Device	Name and address of the DME that provided the Respironics Device

9. For each Respironics Device in the table above, complete the following:

Respironics Device Name and Serial Number	What date did you start using the Respironics Device?	In general, how many nights per 7 day week do/did you use the Respironics Device?	In general, how many hours per night do/did you use the Respironics Device?	Did you use the Respironics Device during the daytime? (Y/N)	If yes daytime use, approximately how many hours per day do/did you use the Respironics Device?

a. Identify every city and state you have resided in which you used the Respironics Device(s) listed above and the dates of residence for each location.

Dates of residence	Location (city and state)

10. For each Respironics Device listed above, where do/did you store the Respironics Device when it is/was not in use?

Respironics Device Name and Serial Number	**Where was the Respironics Device stored?**

11. Have you paused or stopped your usage of the Respironics Device?

    a. If so, when and for what period of time?

Have you paused/stopped using the Respironics Device?	**When and for what period of time?**

12. Other than advice from your attorneys, identify and describe any advice or guidance you received regarding your use or usage, or continued use or usage, of your Respironics Device(s), including but not limited to any such advice or guidance after the Philips RS recall, including from your Health Care Provider.

13. Have you or anyone on your behalf ever cleaned your Respironics Device?

Respironics Device Name and Serial Number	**Have you or anyone on your behalf ever cleaned your Respironics Device(s)?**	**How did you clean the Respironics Device(s)**	**What products did you use to clean the Respironics Device(s)? (Please identify all products, including any products**

			advertised by third parties as CPAP cleaning devices.)

14. Have you ever noticed any particulate or dark matter in or on the Respironics Device(s)?

    a. If yes, please identify when you first noticed the particulate/dark matter?

    b. Identify any and all evidence you have, if any, that the foam in your Respironics Device actually degraded.

15. Have you used any optional accessories (e.g., humidifier, cleaners, wipes, masks/headgear, tubing hoses, filters, nasal cushions, etc.) in combination with the Respironics Device?

    a. If yes, please complete the chart below.

Accessory Name	**Accessory Type**	**From Whom Did You Acquire the Accessory?**	**When Did You Acquire the Accessory?**

16. When did you first hear about the recall notification for your Respironics Device?

17. Did you participate in the recall?

    a. If yes, when?

    b. What is your Philips Device Registration Confirmation Code Number?

III. PERSONAL INFORMATION

18. Current address and date you moved there:

Current Address	Date you moved there

19. Most recent former address and dates (approximate) during which you resided there:

Most Recent Former Address	Dates during which you resided there (approximately)

20. Social Security Number:

21. Date of birth:

22. Are you currently employed? YES _____ NO _____

If yes, please identify your current employer with name, address and telephone number:

Current Employer	Address	Phone Number

If not, did you leave your last job for a medical reason? YES _____ NO _____

If yes, describe the medical reason:

23. Have you ever been out of work for more than thirty (30) days for reasons related to your health in the past five (5) years? YES _____ NO _____

If yes, please state the approximate dates you were out of work, employer, and health condition:

Approximate Dates you were out of work	Employer at the time	Health Condition

24. Have you ever served in any branch of the military? If yes, please identify.

    a. Were you ever discharged for any reason relating to your medical or physical condition? If yes, state what that condition was:

25. If you have Medicare, please state your Health Insurance Claim Number ("HICN") number:

IV. PERSONAL MEDICAL BACKGROUND

26. Current height and weight:

Height	Weight

27. Approximate weight at date of CPAP prescription:

28. **Medical Conditions:**

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from the time ***beginning ten (10) years before your first use of the Device(s) to the present***? Please select Yes or No for each condition. For each condition for which you answer Yes, please complete the Treating Physician information. For each Treating Physician identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Condition Experienced or Diagnosed	Yes	No	Do Not Know	Treating Physician
Acute Inhalation Injury				
Acute Respiratory Failure				
Allergies or Allergic Reaction				
Asthma				
Atrial Fibrillation				
Bronchitis				
Cancer				
Chronic Obstructive Pulmonary Disease				
Chronic Kidney Disease				
Chronic Sinusitis				
Heart Failure				
Lung Injury or Damage				
Nasal Turbinate Hypertrophy				

Pneumonia				
Pulmonary Fibrosis				
Sarcoidosis				
Sleep Apnea				
Recurrent Esophageal Candida				
Respiratory Infection or Failure				

29. If you have been diagnosed with cancer, which type of cancer were you diagnosed with? For each Treating Physician identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Type of Cancer	**Treating Physician (if different than above in Question 28)**

30. If you were diagnosed with a sleep disorder, please state the disorder and treatment to address the disorder (if any).

Sleep Disorder	**Treatment to address the disorder**

31. **Health Care Providers *(Excluding Mental Health Care Providers)*:** To the best of your recollection, identify each Health Care Provider who has provided treatment to you ***for any reason*** (excluding mental health reasons) in the past ten (10) years and the reason for consulting the Health Care Provider (attach additional sheets as necessary). For each provider identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Name	Address	Approximate Dates/Years of Visits	Reason(s) for Visit or Specialty

32. **Hospitals, Clinics, and Other Facilities**: To the best of your recollection, identify each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility where you have received inpatient or outpatient treatment in the past ten (10) years (including any hospitalization and emergency room treatment) ***for any reason*** (attach additional sheets as necessary). For each hospital, clinic, surgery center, physical therapy or rehabilitation center, or other healthcare facility identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Name	Address	Approximate Admission Date(s)	Reason(s) for Visits

33. **Insurance Carriers**: To the best of your recollection, identify each health insurance carrier which provided you with medical coverage and/or pharmacy benefits for the last ten (10) years, and the policy number (attach additional sheets as necessary). For each insurance carrier identified in this section, please complete an authorization attached as Exhibit A, as explained in Section VI., Paragraph 1.

Insurer Carrier	Policyholder	Policy Number	Approximate Dates of Coverage	Includes DME Coverage (Yes/No/Don't Know)

34. State whether you have been reimbursed or filed a claim for reimbursement under an insurance policy with respect to any of the alleged injuries that form the basis of your Complaint. If so, for each claim, identify the insurance provider with which you filed a claim, the policyholder, the policy number, the claim number, and any reimbursement amount.

35. State whether you have undergone a physical examination in connection with any application for life insurance since January 1, 2010. If so, state the following:

a. The date the examination was conducted;
b. The name of the health care provider who conducted the examination;
c. Whether there is a report of such physical examination;
d. The name of the life insurance company on whose behalf the examination was conducted; and
e. Whether or not your application for life insurance was denied as a result of the physical examination.

36. List all of the prescription medications or over-the-counter medications you have taken for at least three consecutive months in the period during which you used your Device, to the best of your recollection, and attach additional sheets as necessary. Please also list any medications for any length of time if they were prescribed for your alleged injury. For each prescriber identified in this section for a medication prescribed for an alleged injury, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Medication Name	**Condition for Prescription**	**Prescriber Name and Address**	**Date of First Prescription**	**Medication prescribed for alleged injury Yes/No?**

37. Have you ever used tobacco products or smoked marijuana, including cigarettes, e-cigarettes (e.g., vaping), cigars, pipes, and/or chewing tobacco/snuff?

a. If you answered yes, please complete the chart below.

Tobacco Product	**Date Started**	**Date Ceased (or Ongoing)**	**Frequency of Use**
Cigarettes			
E-Cigarettes/Vape Pens			
Cigars			
Pipes (including Hookah)			
Chewing Tobacco			
Snuff			
Any other Nicotine Product			
Marijuana			

38. Other Exposure

a. State whether you are aware of, or have reason to believe, you may have been exposed to chemicals or toxins either at your current or former places of work or residences.

b. During your career have you ever to your knowledge worked on or nearby dangerous or hazardous materials (e.g., asbestos, chemicals, auto-body paints, brake-lining, mining, nuclear reactors, shipyards, etc.)?

c. If yes, please complete the chart below.

Name of Employer	**Address and Telephone Number**	**Dates of Employment**	**Type of Business and Position**

V. INJURIES AND DAMAGES

39. Are you claiming any physical injuries or illness because of the Device?

    a. YES ____ NO _____

    b. If yes, please describe in detail the following:

        i. For each provider identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

Physical Injury or Illness	**Approximately when the symptoms began**	**Is the injury or illness continuing?**	**When were you diagnosed with this injury or illness**	**Who diagnosed the injury or illness?**	**Where was the injury or illness diagnosed?**

40. Identify the Health Care Provider(s) who treated you for the injuries you claim in this case. For each Health Care Provider identified in this section, please complete an authorization attached as Exhibit C, as explained in Section VI., Paragraph 3.

41. Identify whether, before you began using your Respironics Device, you suffered from the injury you are alleging in your Complaint as having been caused by your use of a Respironics Device.

42. State whether there is any history in your family of the same type of condition, disease or injury you are alleging in your Complaint as having been caused by your use of a Respironics Device, and if so, identify the family member and their condition, disease or injury.

43. Are you making a claim for lost wages or lost earning capacity?

44. State whether you have ever filed a claim (including a claim for worker's compensation or social security disability) or instituted a legal proceeding (including any previous legal proceedings regarding a Respironics Device) for any personal injury. If so, state the following:

    a. The date of the claim;
    b. The nature of the injuries and damages claim;
    c. The place of filing for each claim or legal proceeding;
    d. The full names and addresses of all parties to the action;
    e. The name of the court or other forum;
    f. The title of the action and case number;

g. The current posture of the claim or legal proceedings; and
h. The final result of each completed claim or legal proceeding, including any monetary judgment, settlement, or award.

VI. AUTHORIZATIONS

All Litigating Plaintiffs must complete the following authorizations as necessitated by your responses to the foregoing sections (You may not provide a blank authorization. All authorizations must be completed and include the addressee):

1. Authorization for Release of Insurance Records. For each company listed in your response to Section IV., Question 31, please provide a completed and signed (***but undated***) Authorization for Release of Insurance Records in the form attached as **Exhibit A**.

2. Medicare Authorization Form. If you identified an HCIN in Section III, Question 21, please provide a completed and signed (***but undated***) Medicare Authorization Form in the form attached as **Exhibit B**.

3. Limited Authorization to Disclose Health Information. For each health care provider, physician, prescriber, pharmacy, DME, retailer, hospital, clinic, surgery center, physical therapy or rehabilitation center, other healthcare facility, and government agency identified in your responses to Questions 8, 28, 29, 31, 32, 36, 39 and 40, please provide a completed and signed (***but undated***) Limited Authorization to Disclose Health Information records in the form attached as **Exhibit C**.

4. Authorization and Consent to Release Psychotherapy Notes. If you have sought professional treatment for your emotional distress you are alleging as a result of your device usage, please, provide a completed and signed (***but undated***) Health Care Authorization in the form attached as **Exhibit D**.

5. Authorization for the Release of Employment Records. If you are asserting a claim for lost wages or a reduction in or loss of earning capacity, please provide a completed and signed (***but undated***) Employment Authorization in the form attached as **Exhibit E**.

6. Limited Authorization for Release of Workers' Compensation Records. If you have applied for workers' compensation, please provide a completed and signed (***but undated***) Authorization for Release of Workers' Compensation Records for each agency or company you submitted your application to in the last ten (10) years in the form attached as **Exhibit F**.

7. Consent for Release of Social Security Information and Release for Social Security Earning Capacity. If you are asserting a claim for lost wages or a reduction in earning capacity, please provide a completed and signed (***but undated***) Consent for Release of Information for Social Security records and the Release for Social Security Earning Capacity in the forms attached as **Exhibit G(1) and G(2)**. If you are **not** asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide the Social Security Authorizations.

8. Tax Return 4506 Form. If you are asserting a claim for lost wages or a reduction in earning capacity, please provide a completed and signed (***but undated***) IRS Form 4506 attached as **Exhibit H** for each year identified. If you are **not** asserting a wage loss claim or a reduction in lost earning capacity, you are not required to provide IRS Form 4506.

9. Limited Authorization to Disclose Health Information. Please provide a completed and signed (***but undated)*** Limited Authorization to Disclose Health Information in the form attached as **Exhibit I**, addressed to Philips RS North America LLC, only, in connection with record collection from Care Orchestrator, Dream Mapper and/or EncoreAnywhere. All plaintiffs must complete a signed but undated Exhibit I.

VII. RELEVANT DOCUMENTS

REQUEST NO. 1: Produce all non-privileged documents you reviewed that assisted you in the preparation of your responses to this PFS.

REQUEST NO. 2: Produce all medical records and/or documents relating to the use of the Respironics Device(s) from any Health Care Provider who treated you in the past ten (10) years and who treated you for any disease, condition, or symptom referred to in any of your responses to the questions above and concerning any condition you claim is related to the use of the Respironics Device(s), including, but not limited to, all imaging studies of any part of your body, and laboratory, pathology, and biopsy reports, that relate in any manner to the diagnosis, treatment, care, or management of your condition and the injuries alleged in your Complaint.

REQUEST NO. 3: Produce all documents you reviewed, utilized or relied on in responding to the PFS.

REQUEST NO. 4: Produce all documents and communications regarding your Respironics Device(s) and/or your Other Device(s), including but not limited to documents regarding any modifications or changes made to your Respironics Device(s).

REQUEST NO. 5: Produce all documents and communications regarding your insurance coverage from the date you acquired your Respironics Device(s) to the present.

REQUEST NO. 6: Produce all documents and communications regarding any application for life insurance you submitted from January 1, 2010 to the present, including but not limited to any reports of physical examinations conducted therewith and any approval or denial notification from the insurance company.

REQUEST NO. 7: Produce all documents and communications for any claim (including a claim for worker's compensation or social security disability) or legal proceeding for any personal injury you filed from January 1, 2010 to the present.

REQUEST NO. 8: Produce all documents regarding the cleaning (if any) of your Respironics Device(s), including but not limited to all documents reflecting any products used to clean your Respironics Device, the frequency of the cleaning of your Respironics Device(s), and any communication with any person regarding the cleaning of a Respironics Device.

REQUEST NO. 9: Produce all documents regarding any particulate or dark matter in your Respironics Device(s), including but not limited to any photos or videos of your Respironics Device(s) and any other evidence that you believe shows that the foam in your Respironics Device(s) actually degraded.

REQUEST NO. 10: Produce all documents regarding any diagnosed medical conditions or injuries you suffered within the last 20 years, and any medications or treatments that you have been prescribed within the last 20 years, involving the lungs, throat, nose, mouth, respiratory tract, or any other part of the body that you claim was injured from use of a Respironics Device.

REQUEST NO. 11: If you are seeking lost wages, all paystubs and employment contracts from three years prior to the date for which you are seeking lost wages, through the last day for which you are seeking lost wages.

REQUEST NO. 12: Produce all documents regarding the Philips RS North America LLC recall.

VIII. DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States that (i) all the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge; (ii) that I have supplied all the documents requested in Section VII above to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers; and (iii) that I have supplied the authorizations attached to this declaration.

Date: _____

Signature: _____

Printed Name: _____

Location: _____

Exhibit A

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all forms regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, records, notes or invoices and bills, which may be in your possession.

_____
Name of Insured

whose date of birth is _____ and whose social security number is: _____

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records.

Litigation Management Inc.,
Name of Representative

Third Party Record Requestor
Representative Capacity (e.g., attorney, records requestor, agent, etc.)

PO Box 241370
Street Address

Cleveland, OH 44124
City, State and Zip Code

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given fuli force and effect to release information of any of the foregoing learned or determined after the date hereof, if is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as through the original had been presented to you.

_____ _____
Name/Signature Date

Exhibit B

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:
Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:	
Address:		
City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- Release **all** records to date
- Release records in timeframe from start date _____ to end date: _____

NY residents only:
- Include all records
- Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:
- One-time disclosure
- Expiration upon specified date _____
- Expiration upon specified event _____

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

☐ Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name

Litigation Management Inc.,

Recipient 1 Email Address

Recipient 1 Mailing Address:

PO Box 241370, Cleveland, OH 44124

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

☐ At the request of the individual

☐ Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

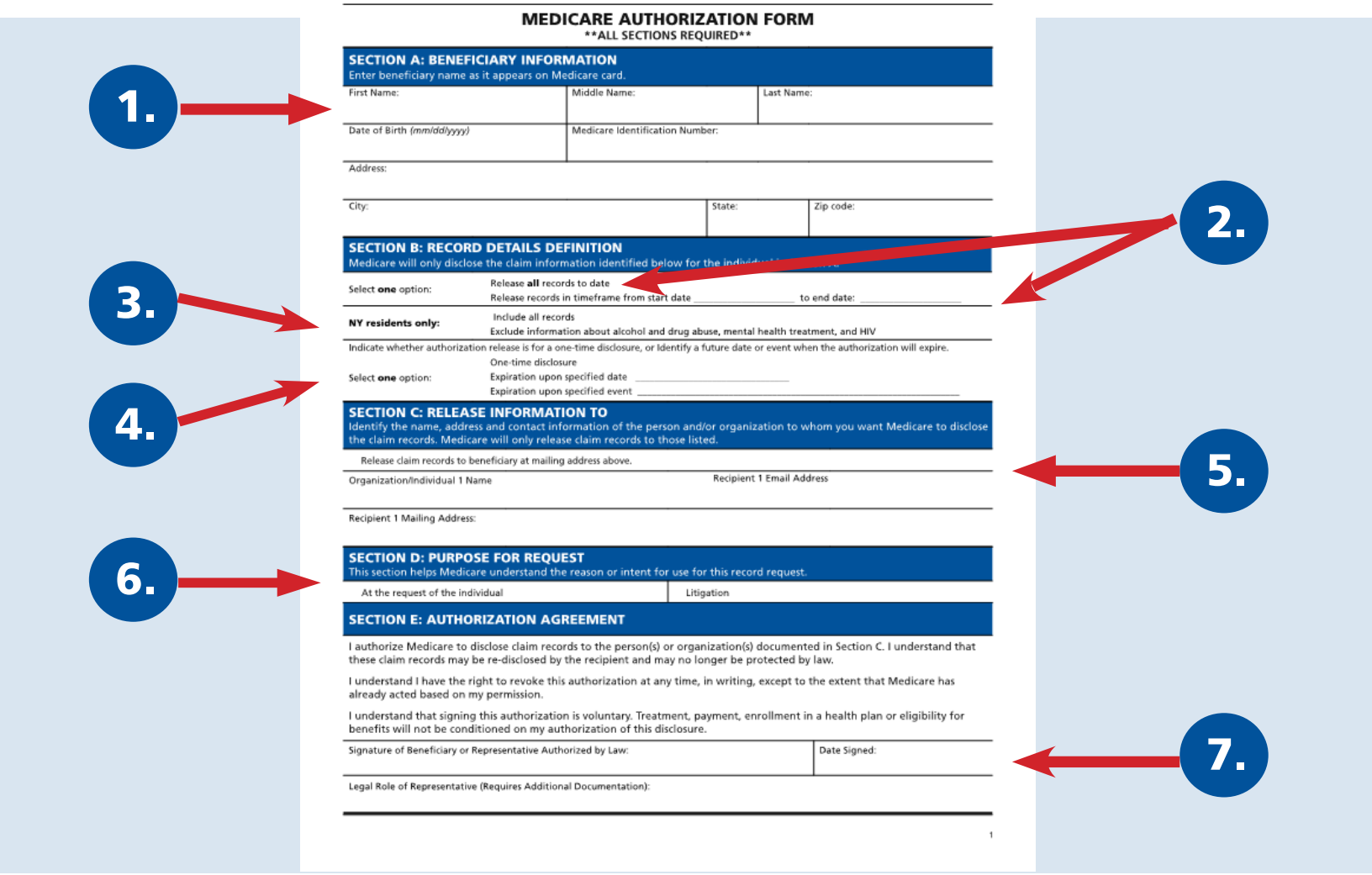
I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

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

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:

Legal Role of Representative (Requires Additional Documentation):

Reset All Check Fields



1. BENEFICIARY INFORMATION

Add beneficiary name and ID number as printed on Medicare identification card, date of birth, and address.

2. RECORD TIMEFRAME

Indicate date range of records to release, or select "release all records."

3. NY RESIDENTS: EXCLUSIONS OPT-IN

(NY residents only) Specify whether to exclude records related to alcohol and drug abuse, mental health treatment, and HIV.

4. SELECT EXPIRATION DATE OR EVENT

Indicate date or event information release authorization will expire, if you are not requesting a one-time disclosure.

5. SPECIFY ORGANIZATION TO RELEASE TO

Specify individual(s) to whom records should be released. First name, last name, and address are required. Additional contact information provided will be used only to follow up on questions related to your application submission.

6. SELECT REASON FOR REQUEST

Select purpose for record release request to help Medicare understand how records will be used.

7. BENEFICIARY SIGNATURE

Signature and date by beneficiary or authorized representative in acceptance of HIPAA clauses required to release information. If form not signed by beneficiary, attach notarized Power of Attorney (living individual), or Letters Testamentary and/ or Letters of Administration from the court (deceased individual).

Exhibit C

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I,_____, hereby authorize you to release and furnish to: Litigation Management Inc., PO Box 241370, Cleveland, OH 44124 COPIES ONLY of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, electronic medical data including information from Care Orchestrator and/or other databases, office and doctor's handwritten notes, and records received by other physicians. Said medical records may include all information regarding AIDS and HIV status.
* All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my

insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If 1 have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____(plaintiff/representative)

Signature: _____ _____

Date

Exhibit D

THIS SHOULD ONLY BE COMPLETED IF YOU HAVE SOUGHT PROFESSIONAL TREATMENT FOR YOUR EMOTIONAL DISTRESS YOU ARE ALLEGING AS A RESULT OF YOUR DEVICE USAGE.

AUTHORIZATION AND CONSENT TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual: _____

Social Security Number: _____

Date of Birth: _____

Provider Name: _____

TO: All physicians, hospitals, clinics and institutions, pharmacists and other healthcare providers;

The Veteran's Administration and all Veteran's Administration hospitals, clinics, physicians and employees;

Social Security Administration; and

Department of the Treasury/Internal Revenue Service;

Open Records, Administrative Specialist, Department of Workers' Claims;

All employers or other persons, firms, corporations, schools and other educational institutions;

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to Litigation Management, Inc. PO Box 241370, Cleveland, OH 44124 and its authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164-501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling, session, and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

- This authorization provides for the disclosure of the above-named patient's protected health information for purposes of the following litigation matter: _____ _____ _____

- The undersigned individual is hereby notified and acknowledges that any health care provider or health plan disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either Litigation Management (PO Box 241370, Cleveland, OH 44124) and/or to one or more entities listed in the above categories, except to the extent that any such entity has taken action in reliance on this authorization.

- The undersigned is hereby notified and acknowledges that he or she is aware of the potential that protected health information disclosed and furnished to the recipient pursuant to this authorization is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HEPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Litigation Management, Inc, pursuant to this authorization will be shared with any and all co-defendants in the matter of _____ _____ and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of _____ (ii) one (1) year after the date of signature of the undersigned below.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Litigation Management, Inc. PO Box 241370, Cleveland, OH 44124, and its authorized representatives, by any entities included in the categories listed above.

Date:_____ _____

Signature of Individual or Individual's Representative

Printed Name of Individual's Representative (If applicable) _____

_____

Relationship of Representative to Individual (If applicable) _____

_____

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR Parts 160 and 164 (collectively, "HIPAA").

Exhibit E

THIS SHOULD ONLY BE COMPLETED IF YOU ARE ASSERTING A CLAIM FOR LOST WAGES OR A REDUCTION IN OR LOSS OF EARNING CAPACITY.

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my employment records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

This will authorize you to furnish copies of alt applications for employment; resumes; records of all positions held; job descriptions of positions held; wage and income statements and/or compensation records; wage increases and decreases; performance evaluations, reviews and reports; transfers, statements and comments of fellow employees; all documents relating to discipline including warnings, reprimands, suspensions, terminations, and all other forms of discipline; attendance records; W-2s, worker's compensation files; all medical records, x- rays and test results; any physical examination records; all documents relating to my absences, illnesses and injuries; any records pertaining to claims made relating to health, disability or accidents in which 1 was involved including correspondence, reports, claim forms, questionnaires, records of payments made to me or on my behalf; and any other records relating to my employment and/or in my personnel file.
Information about HIV/AIDS and alcohol/substance abuse may be disclosed.

I authorize you to release the information to;

_____
Name (Records Requestor)

_____
Street Address City State and Zip Code

I intend that this authorization shall be continuing in nature. If information responsive to this

authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not i sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires _____ or at the conclusion of the case, whichever occurs first.

_____

Signature of Employee or Personal Representative Date Name of Employee or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Employee (attach documents that show authority)

Exhibit F

To be executed only if you have filed a claim for workers compensation in the last ten (10) years.

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
WORKERS' COMPENSATION AUTHORIZATION

TO: _____

RE: Name: _____ aka _____

Date of Birth: _____Social Security Number: _____

Address: _____

I authorize the disclosure of my Workers' Compensation records including any medical information protected by HIPAA, 45 CFR 164.508, for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and complete records including the following:

all workers' compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____.

I authorize you to release the information to Litigation Management Inc., P.O. Box 241370, Cleveland, OH 44124.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the Records Requestor at that time.

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I further

acknowledge that information about HIV/AIDS and alcohol/substance abuse may be disclosed. I also understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not the individual signs the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires _____ or at the conclusion of the case, whichever occurs first.

Print Name: _____ **(plaintiff/representative)**

Signature: _____ **Date:** _____

Exhibit G(1)

To be executed only if you have filed a claim for social security disability and are asserting a claim for lost wages or a reduction in earning capacity.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**

LITIGATION MANAGEMENT, INC.

***ADDRESS OF PERSON OR ORGANIZATION:**

6000 PARKLAND BOULEVARD

MAYFIELD HEIGHTS, OH 44124

***I want this information released because:** to be used in support of an active litigation.

We may charge a fee to release information for non-program purposes.

Invoices can be sent via fax to: 440-484-2055, please reference the PacketID number found above Social Security Disability on the request letter.

Please feel free to contact Litigation Management, Inc. directly at (888) 803 - 8706 with any questions.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☒ My benefit or payment amounts from date _____ to date PRESENT.
5. ☒ My Medicare entitlement from date _____ to date PRESENT.
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☒ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Documents or other items relating to my social security claims(s): applications, questions, petitions, payment documents/decisions/awards/denials, jurisdictional documents/notes, transcripts, correspondence, findings, notice of hearings, hearing records, orders, depositions, reports; witnesses, medical reviewers and experts consultative examination reports, current developments/temporary, non-disability development and documentation, medical records and determination records.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Exhibit G(2)

To be executed only if you are asserting a claim for lost wages or a reduction in earning capacity.

Form **SSA-7050-F4** (02-2021)
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

*Use This Form If You Need

1. **Certified/Non-Certified Detailed Earnings Information**
   Includes periods of employment or self-employment and the names and addresses of employers.

2. **Certified Yearly Totals of Earnings**
   Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are free to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, allows us to collect this information. In addition, the Budget and Accounting Act of 1950 and Debt Collection Act of 1982 authorize us to collect credit card information, if you choose to pay for the earnings information you have requested with a credit card. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from processing your request.

We will use the information to identify your records, process your request, and send the earnings information you request. We may also share the information for the following purposes, called routine uses:

1. To the Internal Revenue Service (IRS) for auditing SSA's compliance with the safeguard provisions of the Internal Revenue Code of 1986, as amended.

2. To contractors and other Federal agencies, as necessary, for the purpose of, assisting the Social Security Administration (SSA) in the efficient administration of its programs.

3. To banks enrolled in the Treasury credit card network to collect a payment or debt when the individual has given his/her credit card number for this purpose.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System, 60-0090, entitled Master Beneficiary Record, 60-0224, entitled SSA-Initiated Personal Earnings and Benefit Estimate Statement, and 60-0231, entitled Financial Transactions of SSA Accounting and Finance Offices. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) One SSN per request

Date of Birth: Date of Death:

Other Name(s) Used
Maiden Name

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

☐ **Itemized Statement of Earnings $92.00**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Year(s) Requested: to
Year(s) Requested: to

☐ Check this box if you want the earnings information **CERTIFIED** for an additional $30.00 fee.

☐ **Certified Yearly Totals of Earnings $30.00**
(Does not include the names and addresses of employers)Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name	Litigation Management, Inc.		
Address	PO Box 241370	State	OH
City	Cleveland	ZIP Code	44124

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature AND Printed Name of Individual or Legal Guardian	*SSA must receive this form within 120 days from the date signed* Date
Relationship (if applicable, you must attach proof)	Daytime Phone:
Address	State
City	ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for one ONE Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $92.00 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $30.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $30.00 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNING INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011	If using private contractor such as FedEx mail form, supporting documentation, and application fee to: **Social Security Administration** P.O. Box 33011 Baltimore, Maryland 21290-33011

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$92.00	$122.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $30.00. You may obtain non-certified yearly totals FREE of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	Area Code
Credit Card Number	
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $30.00, $92.00, or $122.00. SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	Date

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

Exhibit H

To be executed only if you are asserting a claim for lost wages or a reduction in earning capacity.

Form **4506**

(Novmeber 2021)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.
Litigation Management Inc, 6000 Parkland Blvd, Mayfield Heights, OH 44124 888-803-8706

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ **1040**

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☑

7 **Year or period requested**. Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

____/____/_____ ____/____/_____ ____/____/_____ ____/____/_____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	**$**
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	**$**
9	If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here	☑

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☑ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions)	Date
Print/Type name	**Title** (if line 1a above is a corporation, partnership, estate, or trust)
Spouse's signature	Date
Print/Type name	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

Exhibit I

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO: Philips RS North America LLC

Patient Name: _____

DOB: _____

SSN: _____

I,_____, hereby authorize you to release and furnish to: Litigation Management Inc., PO Box 241370, Cleveland, OH 44124 COPIES ONLY of the following information:

* All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, electronic medical data including information from Care Orchestrator and/or other databases, office and doctor's handwritten notes, and records received by other physicians. Said medical records may include all information regarding AIDS and HIV status.
* All reports of autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
* All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
* All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
* All billing records including all statements, itemized bills, and insurance records.

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the defendants and has been approved by the Court supervising this litigation. This authorization is for the sole purpose of allowing copies of my medical records to be provided to the defendants in this litigation. It does not allow discussions of my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition.

2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about treatment for alcohol and drug abuse.

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my

insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If 1 have questions about disclosure of my health information, I can contact the releaser indicate above.

5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____(plaintiff/representative)

Signature: _____ _____

Date