This Order hereby supersedes and replaces all prior Notices and Orders Regarding Service of Plaintiff's Fact Sheets, Records Authorizations, and Applications for Extension of Service Dates filed on 12/1//2021, 11/16/12, 2/14/14, 12/15/16, 7/30/18, and 3/15/2019

Kelly S. Crawford – NJ Attorney ID #029141993
RIKER DANZIG LLP
Headquarters Plaza
One Speedwell Avenue
Morristown, NJ 07962-1981
(973) 538-0800

Attorneys for Defendants,
Ethicon, Inc. and Johnson & Johnson

FILED
JUN 30 2022
RACHELLE L. HARZ
J.S.C.

IN RE PELVIC MESH/GYNECARE LITIGATION,	SUPERIOR COURT OF NEW JERSEY LAW DIVISION - BERGEN COUNTY MASTER DOCKET NO. BER-L-11575-14 CIVIL ACTION In re Pelvic Mesh/Gynecare Litigation Case No. 291 **UPDATED AND AMENDED NOTICE AND ORDER REGARDING SERVICE OF PLAINTIFF'S FACT SHEETS, REQUIRED RECORDS AUTHORIZATIONS AND APPLICATIONS FOR EXTENSION OF SERVICE DATES (UPDATED ~~July~~ June 30 2022)**

TO: All Counsel of Record

PLEASE TAKE NOTICE that, in accordance with Case Management Order No. 5, and in order to ensure uniformity in the service of Plaintiffs' Fact Sheets ("PFS"), the following protocols have been put into place regarding the service of PFSs and applications for extension of service dates. To the extent any of the below protocols deviates from previously entered orders, the below procedures are to be followed beginning immediately upon the entry of this Order for all cases subject to this MCL.

1. **SERVICE OF PFSs**

    a. PFSs are not to be served prior to service of the plaintiff's Complaint. In the event that the PFS is served before the Complaint, Defendants will calculate the due date of the Defendants' Fact Sheet ("DFS") from the date of service of the Complaint.

    b. PFSs are to be served on a rolling basis and are not to be accumulated for mass service. Any one firm shall serve no more than two (2) PFSs in one day to avoid both the imposition of an unreasonable burden on Defendants to process and serve DFS responses within the time contemplated by governing CMO No. 5, and the contravention of this Court's directive for Plaintiffs to avoid such unnecessary burdens.

    c. PFSs and supporting documents for multiple plaintiffs are not to be served electronically in a combined file. While size limitations may require scanned documents to be served in multiple separate files, any electronic file (e.g. pdf) of a PFS response or supporting documents must contain information as to a single plaintiff. For example, a single pdf file may not contain PFS responses or supporting documents for more than a single plaintiff.

d. PFSs are to be served upon Defendants via email addressed to the following individuals:

   i. William Carlucci – wcarlucci@riker.com

   ii. Debra Gantert – dgantert@riker.com

   iii. Francesca Henry – fhenry@riker.com

   iv. Butler Snow – njpfs@butlersnow.com

Service to any subset of the above individuals, service to Defense liaison counsel, or service to other employees of the law firms identified above, is not adequate and may result in motion practice seeking, among other things, dismissal of the complaint.

e. Plaintiffs' counsel may also serve PFSs via regular mail. In the event that counsel chooses this method, the PFSs should be sent to:

Debra Gantert
Francesca Henry
Riker Danzig LLP
Headquarters Plaza
One Speedwell Ave.
Morristown, NJ 07962

Chelsea Palmer
Butler Snow LLP
Suite 1400
1020 Highland Colony Pkwy
Ridgeland, MS 39157

Service via regular mail <u>must</u> be supplemented with service via email to the recipients identified in Section 1(d).

f. To accommodate the size of the files, Plaintiffs' counsel may serve plaintiffs' medical records and authorizations separately via regular mail. These records are to be sent to Debra Gantert, Francesca Henry and Chelsea Palmer as indicated in Section 1(e).

g. PLEASE TAKE NOTICE OF THE PROCEDURE CHANGE REGARDING RECORDS COLLECTION SET FORTH AT Paragraph 5, BELOW. If plaintiffs choose to opt-out of records collection by the medical records vendor, which is not preferable, notice must be sent via email and regular mail to Debra Gantert, Francesca Henry and Chelsea Palmer as indicated in Section 1(e) & (f).

2. **APPLICATIONS FOR EXTENSIONS**

a. Applications to Defendants for extension of the PFS service date are to be sent via email to the following individuals:

i. William Carlucci – wcarlucci@riker.com

ii. Debra Gantert – dgantert@riker.com

iii. Francesca Henry – fhenry@riker.com

iv. Butler Snow – njpfs@butlersnow.com

b. Each application must include the name and docket number of the plaintiff at issue and the length of time needed to complete the PFS.

c. Extension requests are expected to be the exception, and not routine.

3. **COMMUNICATIONS REGARDING DEFICIENCIES IN PFS RESPONSES**

a. All Communications relating to Deficiencies in PFS responses, including, but not limited to supplemental responses, additional responsive information, objections to claims of deficiencies, or extension related requests, are to be sent via email to the following individuals:

i. William Carlucci – wcarlucci@riker.com

ii. Debra Gantert – dgantert@riker.com

iii. Francesca Henry – fhenry@riker.com

iv. Butler Snow – njpfs@butlersnow.com

b. Each communications must include the name and docket number of the plaintiff.

c. **Communications regarding deficiencies or extension requests to any subset of the above individuals, to Defense liaison counsel, or to other employees of the law firms identified above, is not adequate.**

4. **GENERAL OBLIGATIONS REGARDING PFS RESPONSES**

a. PFS forms shall be completed with full and correct information to the best of plaintiff's knowledge. A completed Fact Sheet shall be considered interrogatory answers and as responses to requests for production pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure. Such responses require the execution of a **dated** PFS Certification **signed by** the Plaintiff(s). Failure to provide an answer or respond, or failure to properly certify responses, may lead to dismissal under Rule 4:23-5(a) and related protocols established by this Court.

b. The plaintiff certification requirement set forth in paragraph (a), above, extends to required Certifications that there has been no change to the PFS or medical status that may be required from time to time by Court order, and shall not be required for routine supplements and amendments by counsel.

c. All parties are to comply fully with this protocol.

5. **CHANGE TO RECORDS COLLECTION VENDOR AND GENERAL OBLIGATIONS REGARDING RECORDS AUTHORIZATIONS**

a. For all cases filed or otherwise made part of this MCL after the date of this Order and the entry of the accompanying Amendment to CMO 3, plaintiffs are to provide fully-executed (but undated) copies of each of the updated authorizations appended to this Order as Schedule A. Prior forms of authorization appended to prior orders such as CMO No. 5 are now obsolete.[1] Plaintiff is required to

[1] Paragraphs 7 and 8 of CMO 3 entered on 2012 remain in effect but also now include vendor LMI: If a plaintiff's counsel does not wish to enter into the agreement with *Marker* or with *LMI*, plaintiff's counsel will nevertheless

execute *all* of the form authorizations with one exception; if the plaintiff provides with the PFS response a signed certification that no claims are being made for lost wages, then the plaintiff need not execute the IRS forms 4506 and 8821.

b. For all cases filed or otherwise made part of this MCL as of the date of this Order and Amended CMO 3, Records Collection will be conducted by LMI (not the Marker Group). For all cases filed prior to the date of this Order, records will continue to be collected by the Marker Group, unless otherwise agreed between the parties to a particular case.

c. All parties are to comply fully with this protocol and those of Amended CMO 3, also entered on this date.

Last updated: December , 2021

So Ordered:

June 30, 2022

Rachelle L Harz

Honorable Rachelle Lea Harz, J.S.C

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provide executed authorizations with its Plaintiff's Fact Sheets which are fully completed to the best of plaintiffs' and plaintiffs' counsel's ability and knowledge with the names of plaintiffs' treaters, complete and correct addresses for the treating physicians and/or facility, and are generally consistent with the time frame of twenty (20) years prior to the date of plaintiff's initial mesh implant surgery for every physician requested to be identified in the Plaintiffs' Fact Sheet. If plaintiff's counsel does not believe the 20 year time frame is appropriate based on the specific circumstances of the Plaintiff's case, the parties are to meet and confer. If the matter cannot be resolved, the parties are to request a telephonic conference with the Court and in advance of that conference are to submit their respective positions in writing to the Court. (¶ 7) If defense counsel is seeking medical records pertaining to abortion procedures which occurred more than twenty (20) years prior to the date of plaintiff's initial mesh implant surgery, defense counsel must provide support for their position to plaintiffs' counsel and the Court that these abortions are relevant to, impacted, or contributed to the injuries that plaintiff now attributes to the mesh which is the subject matter of her lawsuit. (¶8).

Schedule 1

Updated Records Authorizations

AUTHORIZATION AND CONSENT
TO RELEASE RECORDS AND PROTECTED HEALTH INFORMATION
(Excluding 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

The Social Security Administration

Open Records, Administrative Specialist, Department of Workers' Claims

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

The undersigned individual hereby authorizes each entity included in any of the above categories to disclose and furnish to **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124;** and their authorized representatives, true and correct copies of all records, reports, files, documents, correspondence, memoranda and all other information related to the physical and mental health of the undersigned individual, regardless of the form of such information, including, without limitation, all notes of physicians, nurses, psychologists, counselors, dentists and other persons who have provided or who are providing health care to the undersigned individual, all radiology, pathology (including HIV test results, genetic testing information, and alcohol and drug abuse treatment) and other diagnostic test and laboratory results, records and reports, all prescription records, all surgical procedure records and reports, all dental records, all histories and summaries, all forms and other information related to admission of the undersigned to or discharge of the undersigned from a clinic, hospital or other health care facility, all surgical procedure and other consent forms, all bills, invoices, claim forms, records and other payment information, including payment by Medicaid/Medicare and other public assistance programs, insurance companies and by other persons. Notwithstanding the broad scope of the above disclosure request, the undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR §164.501.

The undersigned also authorizes the disclosure of all records, reports, files, documents, correspondence, memoranda and all other information related to employment of the undersigned, including attendance reports, performance reports, W-2 and W-4 forms, medical reports and/or any and all other records relating to my past and present employment, and all educational records, including all courses taken, degrees obtained, and attendance records.

Further, to the extent such records currently exist and are in the Provider's possession, employment records, workers' compensation records, disability records, social security records, and insurance records, including Medicare/Medicaid and other public assistance claims applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other documents or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, or other). This listing is not meant to be exclusive.

The above list of types of records and other information to be disclosed is intended to be illustrative and not exhaustive. 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: ____________________________ *v. Ethicon, Inc. and Johnson & Johnson, et al.*

- 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 either to Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, 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 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 re-disclosure 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).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler, Snow, O'Mara, Stevens & Cannada, PLLC; Riker, Danzig, Scherer, Hyland & Perretti LLP; and/or The Marker Group, Inc., pursuant to this authorization will be shared with any and all co-defendants in the matter of ____________________________ *v. Ethicon, Inc. and Johnson & Johnson, et al* and is subject to re-disclosure 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).

- I understand that information disclosed under this authorization could relate to, and I hereby authorize the disclosure of, information regarding treatment and testing for drug or alcohol abuse, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), sexually transmitted diseases, Sickle Cell Anemia, Tuberculosis and Genetic testing and counseling.

- I further understand that, pursuant to applicable state law, I may have a right to receive a copy of this authorization as provided in 45 CFR 164.524.

- 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 ______________________ **v. Ethicon, Inc. and Johnson & Johnson, et al. or (ii) five (5) years 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 Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124; and/or and their authorized representatives, by any entities included in the categories listed above.

Date: ____________________

____
Signature of Individual or Individual's Representative

Individual's Name and Address:

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

____

____
Relationship of Representative to Individual (If applicable)

____

____
Description of Representative's authority to act for 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").

AUTHORIZATION AND CONSENT
<u>TO RELEASE PSYCHOTHERAPY NOTES</u>

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

The Social Security Administration

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 **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124;** and their 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: ______________________ *v. Ethicon, Inc. and Johnson & Johnson, et al.*
- 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 **Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, 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 re-disclosure 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).
- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to Butler, Snow, O'Mara, Stevens & Cannada, PLLC , Riker, Danzig, Scherer, Hyland & Perretti LLP, and/or The Marker Group, Inc. pursuant to this authorization will be shared with any and all co-defendants in the matter of ________________________ *v. Ethicon, Inc. and Johnson & Johnson, et al.* and is subject to re-disclosure 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 ____________________ **v. Ethicon, Inc. and Johnson & Johnson, et al. or (ii) five (5) years 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 Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124 and their authorized representatives, by any entities included in the categories listed above.

Date: __________________

____
Signature of Individual or Individual's Representative

Individual's Name and Address:

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

____

____
Relationship of Representative to Individual (If applicable)

____

____

____

____

____
Description of Representative's authority to act for 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").

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ Go to *www.irs.gov/Form8821* for instructions and the latest information.
▶ Don't sign this form unless all applicable lines have been completed.
▶ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

1 Taxpayer information. Taxpayer must sign and date this form on line 6.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☑

Name and address	
Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158	CAF No.
	PTIN
	Telephone No.
	Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address	
Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981	CAF No.
	PTIN
	Telephone No.
	Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters

4 Specific use not recorded on the Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 . . . . ▶ ☐

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature | Date

Print Name | Title (if applicable)

ADDITIONAL DESIGNEES

McCarter & English
100 Mulberry Street
Four Gateway Center
Newark, NJ 07102

The Marker Group, Inc.
13105 Northwest Freeway, Suite 300
Houston TX 77040

Litigation Management, Inc.
6000 Parkland Blvd.
Mayfield Heights, OH 44124

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.

Butler Snow, LLP, PO Box 6010, Ridgeland, MS 29158; Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, PO Box 1981, Morristown, NJ 07962-1981; McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102; The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston, TX 77040; and Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124

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. ▶ ______________

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	$ 43.00
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

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 41721E Form **4506** (Rev. 11-2021)

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	Recipient 1 Email Address
Butler Snow LLP	

Recipient 1 Mailing Address:

P.O. Box 6010, Ridgeland, MS 29158 (See additional Organizations/Recipients attached).

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):

ADDITIONAL ORGANIZATIONS/RECIPIENTS

ORGANIZATION/RECIPIENT 2 NAME AND MAILING ADDRESS:

Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981

ORGANIZATION/RECIPIENT 3 NAME AND MAILING ADDRESS:

McCarter & English, 100 Mulberry Street, Four Gateway Center, Newark, NJ 07102

ORGANIZATION/RECIPIENT 4 NAME AND MAILING ADDRESS:

The Marker Group, Inc., 13105 Northwest Freeway, Suite 300, Houston TX 77040

ORGANIZATION/RECIPIENT 5 NAME AND MAILING ADDRESS:

Litigation Management, Inc., 6000 Parkland Blvd., Mayfield Heights, OH 44124

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) ______ **Medicare Number** (Exactly as shown on the Medicare Card) ______ **Date of Birth** (mm/dd/yyyy) ______

2. Medicare will only disclose the personal health information you want disclosed.

2A: Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:

☐ Limited Information (go to question 2b)

☐ Any Information (go to question 3)

2B: Complete <u>only</u> if you selected "limited information". Check all that apply:

☐ Information about your Medicare eligibility

☐ Information about your Medicare claims

☐ Information about plan enrollment (e.g. drug or MA Plan)

☐ Information about premium payments

☐ Other Specific Information (please write below; for example, payment information)

______

______

2C: NY Residents Only, this section must be completed.
Please select one of the following options: (Please check only one box.)

☐ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
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Expiration Date: 7/31/2021

3. **Check only one box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only

beginning: ________________(mm/dd/yyyy) and ending: ________________(mm/dd/yyyy)

4. **Fill in the reason for the disclosure (you may write "at my request"):**

Litigation

5. **Fill in the name and address of the person or organization to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person for any organization you list below. If you would like to authorize any additional individuals or organizations, please add those to the back of this form.**

Name Litigation Management Inc

Address 6000 Parkland Blvd, Mayfield Heights, OH 44124

Name The Marker Group, Inc.

Address 13105 Northwest Freeway, Suite 300, Houston, Tx. 77040

Form Approved
OMB No. 0938-0930
Expiration Date: 7/31/2021

Note: You have the right to take back (" revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. To revoke authorization, send a written request to the address noted below. Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

6. **I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.**

Signature	Telephone Number	Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

Telephone Number of Personal Representative: ____________________

Personal Representative's Relationship to the Beneficiary: ____________________

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7. **Send the completed, signed authorization to:**

Medicare CCO, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

Print Form

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke authorization, send a written request to the address noted above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

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:	*ADDRESS OF PERSON OR ORGANIZATION:
LITIGATION MANAGEMENT, INC.	6000 PARKLAND BOULEVARD MAYFIELD HEIGHTS, OH 44124
The Marker Group, Inc.	13105 Northwest Freeway, Suite 300, Houston, Tx. 77040

†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.

†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)

Form SSA-3288 (11-2016) uf

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** Year(s) Requested: to
(Includes the names and addresses of employers) Year(s) Requested: to
If you check this box, tell us why you need this information below.

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

☐ **Certified Yearly Totals of Earnings $30.00** Year(s) Requested: to
(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

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 #	