IN RE: PELVIC MESH/GYNECARE LITIGATION	SUPERIOR COURT OF NEW JERSEY LAW DIVISION: ATLANTIC COUNTY CASE NO. 291 CT MASTER CASE 6341-10

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses within a reasonable time if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure and as responses to requests for production pursuant to Rule 4:18 of the New Jersey Rules of Civil Procedure. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definitions:

"Healthcare provider" means any doctor, physician, surgeon, pharmacist, hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

"You" or "Your" refer to the person who received a pelvic mesh product manufactured by Ethicon, Inc. and who is identified in Question I. 1 (d) below.

"Gynecare Mesh Product(s)" refers to any pelvic mesh product manufactured by Ethicon, Inc. that was implanted in you.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. BACKGROUND INFORMATION

1. Please state:

   a. Case caption: _____

   b. Docket number: _____

   c. Court in which case was originally filed: _____

   d. Full name of the person who received the Gynecare Mesh Product, including maiden name:

   _____

   e. Full name and address of the person completing this form, if different from the person listed in 1 (a) above, and the relationship of the person completing this form to the person listed in 1 (a) above:

   _____

   _____

   f. If completing this form in a representative capacity, please state whether you were appointed by a court, which court appointed you, and the date of your appointment: _____

   _____

   g. If you represent a decedent's estate, please state the date of the decedent's death:

   _____

   h. The name and address of the attorney representing you in this case: _____

   _____

2. Your Social Security Number: _____

3. Your date and place of birth: _____

4. Your current residence address: _____

   _____

5. Identify all individuals who currently live or have lived with you at your current address, their relationship to you, and the dates of residence. _____

_____

_____

6. If you have lived at your current address for less than 10 years, provide each of your prior residence addresses from 2000 to the present:

Prior Address	Dates You Lived At This Address	People Who Lived With You At This Address/ Relationship To You

7. Have you ever been married? **Yes** ___ **No** ____

If **Yes** provide the names and addresses of each spouse and the inclusive dates of your marriage to each person._____

_____

_____

8. Do you have children? **Yes** ___ **No** __

If **Yes**, please provide the following information with respect to each child:

9. Have you had any pregnancies other than those that resulted in the births of your children identified above?

Yes ___ No ____ If **Yes,** provide the date and the outcome of each pregnancy:

_____

_____

10. Identify all secondary and post-secondary schools you attended, starting with high school and please provide the following information with respect to each:

11. Please provide the following information for your employment history over the past 10 years:

12. Have you ever served in any branch of the military? **Yes** _____ **No** _____

If **Yes**, please provide the following information:

a. Branch and dates of service:; dates of your service, rank upon discharge and the type of discharge you received: _____

_____

b. Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? **Yes** _____ **No** _____

If **Yes**, state what that condition was: _____

13. To the best of your knowledge, as an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? **Yes** _____ **No** _____

If **Yes**, please set forth where, when and the felony and/or crime:

_____

_____

II. CLAIM INFORMATION

1) Do you claim to have been implanted with a pelvic mesh product manufactured by Ethicon, Inc. (hereafter referred to in these questions as the "Gynecare Mesh Product(s)")? **Yes** _____ **No** _____

If **Yes**:
a) Identify the Gynecare Mesh Product(s) that were implanted in you and provide the product code and lot number specific to that product, if known:

_____

b) Please give the date that the Gynecare Mesh Product(s) was implanted in you:

_____

2) Please identify the type of surgery that you received:

a) TVT: ____
b) TVT-O:_____
c) TVT-Secur:_____
d) Prolift Total: _____
e) Prolift Anterior:_____
f) Prolift Posterior:_____
g) TVT Exact

h) TVT Abbrevo
i) Prolift + M Total: _____
j) Prolift + M Anterior:_____
k) Prolift + M Posterior:_____
l) Prosima
m) Other: _____

3) Identify to the best of your knowledge the medical condition(s) and symptoms you were experiencing, that led to the implantation of the Gynecare Mesh Product(s): _____

_____

_____

_____

4) a) Give the name and address of the doctor who implanted the Gynecare Mesh Product(s):

_____

_____

b) Are you currently being treated by the surgeon identified above?

Yes _____ **No** _____

If **No,** what was the date of your last visit or consultation with the surgeon?

_____

5) To the best of your knowledge, were there any concurrent surgical procedures performed during the surgery in which the Gynecare Mesh Products were utilized? If so please identify the concurrent procedure(s) and the doctor(s) who performed them:

_____

_____

6) Give the name and address of the hospital or other healthcare facility where the Gynecare Mesh Product(s) was implanted: _____

_____

7) Prior to implantation, did you receive any **written or verbal** information or instructions regarding the Gynecare Mesh Product(s), including any risks or complications that might be associated with the use of the product(s)? **Yes** _____ **No** _____

If **Yes:**

a) Provide the date you received the information or instructions: _____

b) Identify by name and address the person(s) who provided the information or instructions: _____

_____

c) If you have copies of the written information or instructions you received, please attach copies to your response.

8) To the best of your knowledge, was the Gynecare Mesh Product(s) that was implanted in you ever removed, in whole or in part?

Yes _____ No _____ I Don't Know _____

If **Yes**:

a) On what date, where and by whom (doctor) was the Gynecare Mesh Product(s), or any portion of it, removed? _____

_____

b) Explain why you consented to have the Gynecare Mesh Product(s), or any portion of it, removed?_____

_____

_____

c) To the best of your knowledge, does any medical treater, physician or anybody else on your behalf have possession of any portion of the Gynecare Mesh Product(s) that was previously implanted in you and removed?

_____

_____

9) To the best of your knowledge, if all or part of the Gynecare Mesh Product(s) remain implanted in you:

Has any doctor recommended removal of the Gynecare Mesh Product(s)?

Yes ____ No ____

If **Yes,** Identify by name and address the doctor who recommended removal and state your understanding of why the doctor recommended removal:

_____

_____

10) Do you claim that you suffered bodily injuries as a result of the Gynecare Mesh Product(s)?

Yes _____ No _____

If **Yes:**

a) Describe the bodily injuries, conditions and/or symptoms that you claim resulted from the Gynecare Mesh Product(s)?

_____

_____

_____

_____

b) When is the first time you experienced bodily injuries, conditions and/or symptoms you have listed above that you now relate to the Gynecare Mesh Product(s)?

_____

_____

_____

_____

c) For each bodily injury, condition and/or symptom you now claim to have experienced relating to the Gynecare Mesh Product(s), please state approximately when you first saw a health care provider for each of those bodily injuries, name of provider and diagnosis, if any, provided:

_____

_____

_____

d) Are you currently experiencing symptoms that you relate to your claimed bodily injuries?

Yes _____ **No** _____

If **Yes**, please describe your current symptoms in detail

_____

_____

_____

_____

e) Are you currently seeing, or have you ever seen a doctor or healthcare provider for any of the bodily injuries, conditions and/or symptoms listed above?

Yes _____ **No** _____

If **Yes,** please list all doctors you have seen for treatment of any of the bodily injuries you have listed above.

f) Were you hospitalized at any time for the bodily injuries, conditions and/or symptoms you listed above?

Yes _____ **No** _____ If **Yes**, please provide the following:

11) To the best of your knowledge, have you been diagnosed with the following:

a) Vaginal Prolapse: Yes _____ No _____
b) Uterine Prolapse: Yes ____ No _____
c) Rectocele: Yes ____ No _____
d) Cystocele: Yes ____ No _____
d) Enterocele: Yes ____ No _____
e) Urinary incontinence: Yes ____ No _____
f) Fecal Incontinence: Yes ____ No _____
g) Urethral Hypermobility: Yes ____ No _____
h) Interstitial Cystitis: Yes ____ No _____

If **Yes**, to (a)-(h) above identify the doctor who communicated the diagnosis, the date of the diagnosis, and the course of treatment recommended:

_____

_____

_____

12) Are you making a claim for lost wages or lost earning capacity?

Yes _____ **No** _____ If **Yes**, please answer the following:

a) State the annual gross income you derived from your employment for each year, beginning five years prior to your surgery until the present:

_____

_____

_____

13) Are you making a claim for lost out-of-pocket expenses?

Yes _____ **No** _____ If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred: _____

_____

_____

14) Are you claiming mental and/or emotional damages?

Yes _____ **No** _____ If **Yes**, what mental and/or emotional damages do you claim and what do you attribute them to?

_____

_____

If you are claiming mental and/or emotional damages, provide the following information for each provider (including but not limited to primary care physicians, psychiatrist, psychologists, therapists, and/or counselors) from whom you have sought treatment for your psychological, psychiatric or emotional conditions at any time:

Name	Address	Condition treated	Dates treated	Medications Prescribed

15) Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the Gynecare Mesh Product(s)?

Yes _____ **No** _____

If **Yes:** Identify by name and address the person who filed the loss of consortium claim, and state the relationship of that person to you.: _____

_____

16) Have you or anyone acting on your behalf, other than your attorneys, had any communication, oral or written, with any of the defendants or their representatives?

Yes _____ **No** _____ **I Don't Know**_____

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

_____

_____

_____

III. MEDICAL BACKGROUND

1) Provide your current age: _____ Height _____ Weight _____

2) At the time you received the Gynecare Mesh Product(s), please state:

Your age _____ Your approximate weight _____

3) In chronological order, list any and all surgeries or hospitalizations you had **BEFORE** implantation of the Gynecare Mesh Product(s) for treatment of a gynecological, urological, abdominal and/or colo-rectal condition, excluding child births. Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

[Attach additional sheets as necessary to provide the same information for any and all surgeries leading up to implantation of the Gynecare Mesh Product(s)]

4) In chronological order, list any and all surgeries or hospitalizations you had **AFTER** the implantation of the Gynecare Mesh Product(s) for treatment of a gynecological, urological, abdominal, colo-rectal and/or mesh-related condition, excluding child births. Identifying by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

		Doctor or Healthcare Provider Involved (including address)

5) To the extent not already provided in the charts above, provide the name, address, and telephone number of any internal or family doctor, surgeon or hospital from which you have received medical advice and/or treatment for the past **10 years**:

6) To the best of your knowledge, have you ever been diagnosed by a doctor or another health care provider with any of the following:

	Yes	No
Bleeding or clotting disorders		
Cancer		
Chronic obstructive pulmonary disease/COPD/chronic lung disease/Chronic coughing		
Complications related to childbirth		
Crohn's Disease, Irritable Bowel Syndrome, Ulcerative Colitis, Chronic Diarrhea or disease of the gut, intestines, or bowel		
Connective Tissue Disorder		
Diabetes		
Diverticulitis		
Fistula		
Hernia		
Malnutrition		
Obesity		
Pelvic Tumors or Fibroids		
Peripheral vascular disease or peripheral arterial disease		
Psychological/Mental/Emotional Conditions		
Recurrent constipation		

7) For each condition for which you answered **Yes** in the previous chart, or otherwise identified above, please provide the information requested below (attach additional sheets as needed):

[illegible]	[illegible]	[illegible]	[illegible]	Current Status of Condition

8) Have you experienced menopause? **Yes** _____ **No** _____

If **Yes**, at what age did it begin? _____

9) Have you undergone vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy (ERT)? **Yes** _____ **No** _____

If **Yes**,

a) Were you receiving vaginal estrogen therapy, hormone therapy, or systemic estrogen replacement therapy at the time of your implantation surgery?

Yes _____ **No** _____

b) Please provide the type of therapy you received, date(s) of the therapy, and the name and address of the healthcare provider providing the therapy.

_____

_____

10) Have you received a hysterectomy? If so please state the doctors' name, city and state and date.

_____

_____

11) Do you now or have you ever smoked tobacco products? **Yes** _____ **No** _____

If **Yes**:

a) Provide the dates you smoked?

_____

b) How much do/did you smoke?

_____

12) Other than the implantation of the Gynecare Mesh Product(s) that are the subject of your lawsuit, have you had implanted inside of your body any other medical product of any kind, whether a mesh product or other device? **Yes** _____ **No** _____

If **Yes**, please provide the following information:

a) Product Name: _____

b) Date of Procedure Placing it and name and address of Doctor who placed it:

_____

c) Condition sought to be treated through placement of the device :

_____

d) Any complications you encountered with the medical product or procedure :

_____

e) Does that product remain implanted inside of you today? **Yes** _____ **No** _____

13) List each prescription medication you have taken **for more than 3 months at a time, within the last 3 years prior to the implantation of the Gynecare Mesh Product until the present,** giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

IV. INSURANCE INFORMATION

1) Provide the following information, to the best of your knowledge, for any past or present medical insurance coverage within the last 10 years:

2) Are you receiving Medicare benefits due to age, disability, conditions or any other reason or basis?

Yes _____ **No** _____

The date on which you first began receiving such benefits: _____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

3) Has Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last (10) years?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Medicare/Medicaid:_____

b) Address:_____

c) Dates of Service:_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C.

1395y(b)(8), also known as Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

4) Have you ever been denied life insurance for reasons relating to your health?

Yes _____ **No** _____ If **Yes**, please state when the denial occurred, the name of the life insurance company, and the company's reason for denial: _____

_____

5) Have you personally paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by a Gynecare Mesh Product and for which you seek recovery in the action you have filed?

Yes _____ **No** _____

If **"Yes,"** state the total amount of such expenses at this time: $_____

6) Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of a Gynecare Mesh Product and for which you seek recovery in the action you have filed?

Yes _____ **No** _____

If **"Yes,"** state the total amount of such expenses at this time: $_____

V. PRIOR CLAIM INFORMATION

1) Have you filed a lawsuit or made a claim in the last 10 years, other than in the present suit relating to any bodily injury?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Court in which suit/claim filed or made:_____

b) Case/Claim Number:_____

c) Nature of Claim/Injury:_____

2) Have you applied for workers' compensation (WC), Social Security disability (SSI or SSD) benefits, or other state or federal disability benefits within the past 10 years?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Date (or year) of application: _____

b) Type of benefits sought _____

c) Agency/Insurer from which you sought the benefits:_____

d) The nature of the claimed injury/disability: _____

e) Whether the claim was accepted or denied: _____

_____

3) Have you ever filed for bankruptcy?

Yes _____ **No** _____ If **Yes**, please specify the following:

a) Court in which petition was filed: _____

b) Case/claim number: _____

c) Resolution of case: _____

VI. FACT WITNESSES

1) Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

VII. ELECTRONICALLY STORED INFORMATION

For the three years prior to implantation of the Gynecare Mesh Product(s) to present, please identify any websites that you own, maintain, use for social networking, instant messaging, tweeting, blogging, or otherwise posting messages on-line including MySpace and Facebook where you have posted anything with regard to your lawsuit, claims or the Gynecare Mesh Product(s), aside from communications with your attorneys, and provide the name or identity used by you in connection with those websites or postings.

_____

_____

_____

VIII. AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Ethicon, Inc. and/or its attorneys or agents to obtain those records identified in the authorizations, and send those executed authorizations immediately to:

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

713.460.9070 *main*
713.934.2586 *fax*

IX. DOCUMENTS

State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents, with this completed Fact Sheet.

a) If you were appointed by a court to represent the plaintiff in this lawsuit, produce any documents demonstrating your appointment as such.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

b) If you represent the estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

c) Produce any communications in your possession (sent or received) concerning the Gynecare Mesh Product(s), including e-mails, letters, blog entries and newsletters. Social media websites, including but not limited to Facebook, MySpace, Twitter, Friendster, are not included within this request and will be addressed later.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

d) Produce all documents or records in your possession relating to the bodily injuries, conditions and/or symptoms identified in your responses to questions II. (3), (3)(a), (10) and (11) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

e) Produce all documents or records in your possession relating to the surgeries, conditions and/or injuries identified in your responses to questions III. (3), (4) and (6) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

f) If you are advancing a claim for emotional or psychological injuries, produce all documents or records in your possession which refer or relate to any psychological, psychiatric, counseling, mental health treatment that you have received in the last 10 years.

i. Not Applicable

ii. The documents are attached [OR] I have no documents

g) Produce all documents or records in your possession relating to the prescriptions identified in your response to question III. (13) of this Fact Sheet.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

h) Produce documents, including notes, diary or journal entries, and sufficient photographs, DVDs, videos, or other media to show: (1) the conditions which led to the surgery in which you received a Gynecare Mesh Product, or (2) the injuries or conditions for which you claim relief in this lawsuit. This request is limited to the time period beginning three years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

i) Produce any Gynecare Mesh Product packaging, labeling, advertising, patient brochures, or any other Gynecare Mesh Product -related items in your possession.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

j) Produce all documents concerning any communication between you and the Food and Drug Administration (FDA) or between you and any employee or agent of the Defendants, regarding the Gynecare Mesh Product(s) at issue.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

k) Produce all documentation in your possession of correspondence or communication between Ethicon, Inc., Johnson & Johnson (or any of its related companies or divisions) and any of your doctors, healthcare providers, and/or you relating to the Gynecare Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

l) Produce any and all documentation in your possession of any instructions or warnings you received prior to implantation of any Gynecare Mesh Product(s) concerning the risks and/or benefits of your surgery, including but not limited to any risks and/or benefits associated with the Gynecare Mesh Product(s).

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

m) Produce any and all documents reflecting the product code and lot number of the Gynecare Mesh Product(s) you received.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

n) If you claim lost wages or lost earning capacity, copies of your federal and state tax returns for the 5 years prior to your surgery until the present.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

o) Produce any and all statements by any party or any other person with knowledge relevant to this lawsuit, including their agents, servants, employees, officers or directors, regarding the Plaintiff and her condition, excluding work product.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

p) Produce any and all documents regarding monies expended or expenses incurred for hospitals, doctors, nurses, x-rays, medicines and other health care related to the injuries and/or conditions you allege in this action.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

q) Produce any and all documents which itemize any and all other losses or expenses not otherwise set forth, incurred as a result of your injury and/or condition which forms the basis of this action.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

r) Produce any and all documents which identify money which you have received as a result of your injury and/or condition which forms the basis of this lawsuit.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

s) Produce any and all settlement agreements, releases and forms of payment relating to any other legal proceeding related to your claims and alleged injuries.

i. Not Applicable _____

ii. The documents are attached _____ [OR] I have no documents _____

SWORN DECLARATION

Plaintiff, _____, deposes and states as follows:

I certify under penalty of perjury that all of the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in Section IX of this Fact Sheet to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in Section VIII of this Fact Sheet.

Dated: _____ _____

Signature

Exhibit A

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 LLP; Riker Danzig LLP; McCarter & English; The Marker Group, Inc., and/or Litigation Management, 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
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

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 LLP, Riker Danzig LLP, McCarter & English, The Marker Group, Inc. and/or Litigation Management, 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	CAF No.
Butler Snow LLP, P.O. Box 6010, Ridgeland, MS 29158	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	CAF No.
Riker Danzig LLP, Headquarters Plaza, One Speedwell Avenue, P.O. Box 1981, Morristown, NJ 07962-1981	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**

(November 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. 1545-0428

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

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 one year from signature date

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

Butler Snow, LLP

Recipient 1 Email Address

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

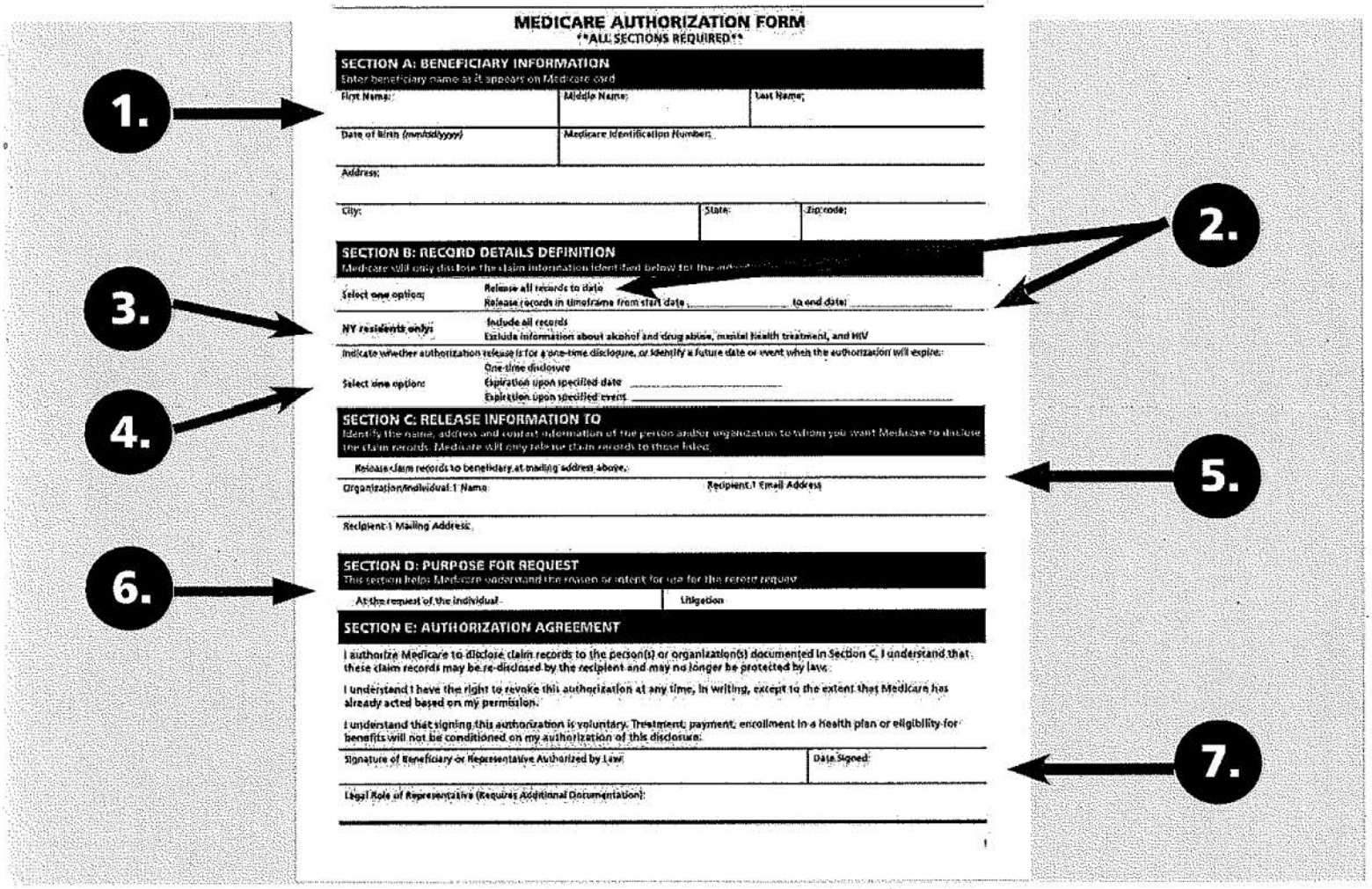
I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

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):



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).

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
Expires: 11/30/2025

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:

After you complete and sign the authorization form, return it to the address below:

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

For New York Medicare Beneficiaries ONLY

The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- **For question 2A,** check the box for Limited Information, even if you want to authorize Medicare to release any and all of your personal health information.
- **Then proceed to question 2B.** You may also check any of the remaining boxes and include any additional limitations in the space provided. For example, you could write "payment information".

Instructions for Completing Section 2C of the Authorization Form:

Please select one of the following options.

- **Option 1** To **include** all information, check the box: "All information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.
- **Option 2** To **exclude** the information listed above, check the box "Exclude information about alcohol and drug abuse, mental health treatment, and HIV". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Enclosure

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/ Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.
   - Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card.
   - Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2A to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2B that apply to the type of information you want Medicare to give out. Box 2C must be completed by New York Residents.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. This section tells Medicare the reason for disclosure.

5. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization.

   If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

6. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

7. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

8. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number seven on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

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.

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

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, Middle, Last, Suffix) of the person with Medicare

Medicare Identification Number (if issued), 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 one 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 only 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.

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

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

3. Check only <u>one</u> 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 Marker Group, Inc.

Address 13105 Northwest Freeway, Suite 300, Houston, TX 77040

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.

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

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 Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

Form Approved
OMB No. 0938-0930
Expires: 11/30/2025

7. Send the completed, signed authorization to:

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

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.

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). You may complete this form to release only the minor's non-medical records, if you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child. We require proof of relationship, if you are not the subject of the record. We may charge a fee for providing the information, if you are requesting the information for a purpose unrelated to the administration of a program under the Social Security Act. If you are requesting information, such as a Social Security Statement or benefit verification letter, you can also access this information by creating an account at https://www.ssa.gov/myaccount/.

NOTE: Do NOT use this form to request:

- **The release of a minor child's medical records. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or**
- **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.

- Fill in the name, date of birth, and social security number of the subject of the record.
- Fill in the name and address of the person or organization of where you want us to send the requested information.
- Specify the reason you want us to release the information (e.g., litigation, investigation, determining eligibility for benefits). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child or legally incompetent adult, you must state how the release of information is in the best interest of the minor child or legally incompetent adult.
- Check the box next to the type(s) of information you want us to release including specific date ranges, where applicable.

NOTE: Unless otherwise specified, the consent form is valid for one-time use only. Also, it is valid for one year from the date of signature, unless you are requesting medical records. A consent form that includes a request for medical records is valid for 90 days from the date of signature.

Send or bring the completed form to the subject of the record's local servicing office. To locate the appropriate servicing office, visit https://secure.ssa.gov/ICON/main.jsp, and input the subject of the record's ZIP code.

Consent for Release of Information

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

TO: Social Security Administration

*Full Name	*Date of Birth (MM/DD/YYYY)	*Full 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: ** PHONE NUMBER OF PERSON OR ORGANIZATION:
Litigation Management, Inc.	6000 Parkland Boulevard, Mayfield Heights, OH 44124
The Marker Group	13105 Northwest Freeway, Ste. 300, Houston, TX 77040

***I want this information released because:**

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

Litigation

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

Check at least one box. If requesting medical records, do not check both boxes 7 and 8. We will not disclose records unless you include specific date ranges where applicable.

1. [x] Verification of Social Security Number
2. [x] Current monthly Social Security benefit amount
3. [x] Current monthly Supplemental Security Income payment amount
4. [x] Social Security benefit amounts from date _____ to date Present
5. [x] Supplemental Security Income payment amounts from date _____ to date Present
6. [x] Medicare entitlement from date _____ to date Present
7. [x] Medical records from date _____ to date Present
8. [ ] Complete medical records
9. [x] Other Social Security record(s) (We will not honor a request for "any and all records" or "the entire file." You must specify which records you are seeking. For example, award/denial notices, benefit applications, appeals)

   Questionnaires; Assessments; Examination Reports; Doctor Reports; Benefit/Claim Applications; Award/Denial Letters;

   Appeals/Hearing Records, DDS Determinations and any documents/correspondence relating to Social Security claims

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 § 1746) 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 seeks or obtains access to records about another person under false pretenses is punishable by a fine of up to $5,000.

***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)

Privacy Act Statement
Collection and Use of Personal Information

The Privacy Act (5 U.S.C. 552a) and Section 205(a) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from honoring the request to release information or records about you. We will use the information you provide to respond to the request for Social Security Administration (SSA) records. We may share the information for the following purposes, called routine uses:

- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

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 (SORN) 60-0089, entitled Claims Folders System, as published in the Federal Register (FR) on April 1, 2003, at 68 FR 15784; 60-0320, entitled Electronic Disability Claim File, as published in the FR on December 22, 2003, at 68 FR 71210; and 60-0340, entitled FOIA and Privacy Act Record Request and Appeal System, as published in the FR on July 13, 2016, at 81 FR 45352. Additional information, and a full listing of all our SORNs, is available on our website at www.ssa.gov/privacy.

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 5 minutes to read the instructions, gather the facts, and answer the questions. 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.***

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 $100.00**
(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 $44.00 fee.

☐ **Certified Yearly Totals of Earnings $44.00**
(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

Address | State

City | ZIP Code

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 $100.00 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 $44.00 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 $44.00 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
$100.00	$144.00

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

Certified yearly totals of earnings cost $44.00. 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 $44.00, $100.00, or $144.00. 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 #	