UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

IN RE:	)	**MDL NO. 2753**
ATRIUM MEDICAL CORP. C-QUR MESH PRODUCTS LIABILITY LITIGATION	)	**MDL Docket No. 1:16-md-02753-LM**
	)	**ALL CASES**

AMENDED PLAINTIFF PROFILE FORM

In completing this Amended Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Amended Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order ("CMO"). Service of the Amended Plaintiff Profile Form shall be via electronic mail to the individuals identified in CMO No. 2.

I. CASE INFORMATION

Caption:

Date:

Docket No.:

Plaintiff's attorney and Contact information: _____

_____

Court where case originally filed or would have been filed absent direct filing into this MDL: _____

II. PLAINTIFF INFORMATION

Name: _____

Maiden Name (if any): _____

Other names by which you have been known (from prior marriages or otherwise):

_____

Male: _____ **Female:** _____

Address: _____

Date of birth: _____

Social Security No.: _____

Spouse's Name:_____**Loss of Consortium? ☐Yes ☐ No**

Spouse's Maiden Name (if any): _____

Other names by which your spouse has been known (from prior marriages or otherwise):

_____

Spouses' Gender Male: _____**Female:** _____

Spouse's Address: _____

Spouse's Date of birth: _____

Spouse's Social Security No.: _____

[1]

III. DEVICE INFORMATION

Date of implant:

Reason for Implantation:

Brand Name: **Mfg.**

Lot Number:

Implanting Surgeon:

Medical Facility:

_____

Date of implant:

Reason for Implantation:

Brand Name: **Mfg.**

Lot Number:

Implanting Surgeon:

Medical Facility:

• ***Attach medical evidence of product identification.***

IV. REMOVAL/REVISION SURGERY INFORMATION

[1] Note: In lieu of device information, operating records may be submitted as long as all requested information is legible on the face of the record

Date of surgery(s) or anticipated surgery(s):

Type of surgery(s):

Explanting surgeon:

Medical Facility:

Reason for Explant:

Location of Explanted Device:

Date of surgery(s) or anticipated surgery(s):

Type of surgery(s):

Explanting surgeon:

Medical Facility:

Reason for Explant:

Location of Explanted Device:

V. OUTCOME ATTRIBUTED TO DEVICE

☐ **Pain**	☐ **Failed graft incorporation**
☐ **Adhesion**	☐ **Recurrence**
☐ **Extrusion**	☐ **Bleeding**
☐ **Infection**	☐ **Seroma**
☐ **Fistulae**	☐ **Erosion**
☐ **Bowel blockage**	☐ **Emotional/psychological injuries with treatment**
☐ **Organ Perforation**	☐ **Emotional/psychological injuries without treatment**
☐ **Abscess**	☐ **Other**

Date of First Diagnosis or Occurrence of Above-Identified Outcome(s): _____

VI. PAST HISTORY

Number of Prior Abdominal Surgeries: _____

Number of Prior Hernia Surgeries: _____

Name of Hospital	Address of Hospital	Type of Surgery	Approx. Date of Surgery

Prior to the First Implant, Have You Ever Had or Been Diagnosed with:

_____ **Lupus**
_____ **Diabetes**
_____ **Auto Immune Disorder**
_____ **Adhesive Disease**
_____ **Disease of the Gallbladder**
_____ **Crohn's Disease**
_____ **Colitis**
_____ **Diverticulitis**
_____ **Hypertension**
_____ **Obesity**
_____ **History of Tobacco Use**

Type of Tobacco (cigarettes, cigars, chewing tobacco)	Frequency of Use (packs per day)	Start date	End date

Are you claiming damages for lost wages: ☐ Yes ☐ No

If so:

For what time period: _____

Identify your employer (and provide address) at the time you incurred lost wages:

_____

_____

Identify your title/occupation at the time you incurred lost wages: _____

_____

Name and Address of each pharmacy where you have had prescriptions filled for the last ten (10) years:

Name of Pharmacy	Address of Pharmacy	Approx. Dates of Use

Provide the following information for any past or present medical insurance coverage within the last ten (10) years:

Name of Insurance Company	Policy Number	Name of Policy Holder/Insured (if different than you)	Approx. Dates of Coverage

Have you applied for social security, or state or federal disability benefits within the past ten (10) years? Yes_____No_____

If Yes, then as to each application, separately state:

1. Was claim denied? Yes_____No_____

2. To what agency or company did you submit your application:

   _____

3. Claim/docket number, if applicable:_____

Have you ever filed for bankruptcy: [ ] Yes [ ] No

If so, when? _____

Do you have a computer: [ ] Yes [ ] No

If so, are you a member of Facebook, LinkedIn or other social media websites: [ ] Yes [ ] No

Which ones: _____

VII. LIST OF ALL TREATING PHYSICIANS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST MESH IMPLANT, INCLUDING ALL PRIMARY CARE PHYSICIANS, SURGEONS, GASTROENTEROLOGISTS, OB-GYNS, UROLOGISTS, ENDOCRINOLOGISTS, RHEUMATOLOGISTS, PSYCHIATRISTS, PSYCHOLOGISTS, OR ANY OTHER SPECIALISTS

PRIMARY CARE PHYSICIANS:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

SURGEONS:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

GASTROENTEROLOGISTS:

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

PSYCHIATRISTS/PSYCHOLOGISTS (Answer only if making a claim for emotional/psychological injury beyond usual pain and suffering):

Name: _____

Address: _____

Approximate Period of Treatment: _____

Name: _____

Address: _____

Approximate Period of Treatment: _____

Attach additional pages as needed to identify other health care providers you have seen.

AUTHORIZATIONS AND DOCUMENT PRODUCTION

1. Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Amended Plaintiff Profile Form.

2. Produce all documents in your possession, custody or control concerning any occasion on which you saw a doctor or other health care provider regarding any injury or physical or psychological complaint for which you claim compensation in this lawsuit, including but not limited to all medical reports and records; psychological assessments and records; and laboratory findings and reports.

i. The documents are attached_____[OR] I have no documents _____

3. Produce all medical and hospital bills or receipts, and documents in your possession, custody or control reflecting any and all payments made for same, including, but not limited to, any hospital and health care professional bills incurred because of the injuries you allege you have incurred as a result of your use of the C-QUR™ Mesh.

i. The documents are attached_____[OR] I have no documents _____

4. Produce any communications in your possession, custody or control (sent or received), excluding communications with your lawyers, concerning the C-QUR™ Mesh, including but not limited to e-mails, blogs, newsletters, etc.

i. The documents are attached_____[OR] I have no documents _____

5. Produce any notes, diaries, or other documents in your possession custody or control evidencing your physical or mental condition, including but not limited to the injuries for which you claim relief in this lawsuit.

i. The documents are attached_____[OR] I have no documents _____

6. Produce any C-QUR™ Mesh packaging, labeling, advertising, or any other C-QUR™ Mesh-related items in your possession, custody or control.

i. The documents are attached_____[OR] I have no documents _____

7. Produce all documents in your possession, custody or control evidencing or relating to any correspondence or communication between Atrium Medical Corporation and any of your doctors, healthcare providers, and/or you relating to the C-QUR™ Mesh .

i. The documents are attached_____[OR] I have no documents _____

8. Produce any and all documents in your possession, custody or control relating to the recall of the C-QUR™ Mesh that you received and/or reviewed at any time prior to filing this lawsuit.

i. The documents are attached_____[OR] I have no documents _____

9. Produce any and all documents in your possession, custody or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of the C-QUR™ Mesh concerning the risks and/or benefits of your hernia repair surgery, including but not limited to any risks and/or benefits associated with the C-QUR™ Mesh.

i. The documents are attached_____[OR] I have no documents _____

10. Produce any and all documents in your possession, custody or control reflecting the size, model number, and lot number of the C-QUR™ Mesh you received.

i. The documents are attached_____[OR] I have no documents _____

11. If you underwent surgery to explant in whole or in part the C-QUR™ Mesh that you received, produce any and all documents in your possession, custody or control relating to any evaluation of the C-QUR™ Mesh and any other material that was(were) surgically removed from you.

i. The documents are attached_____[OR] I have no documents _____

12. Produce any documents, including print outs or screen shots, in your possession, custody or control that refer or relate to C-QUR™ Mesh or hernia repair.

i. The documents are attached_____[OR] I have no documents _____

13. Produce any photographs, digital images, video or similar media in your possession, custody or control that depicts your hernia that was repaired with C-QUR™ Mesh, the incision and or scarring resulting from the C-QUR™ Mesh or hernia repair procedure or revision, if any, and/or any physical condition that you contend was caused by C-QUR™ Mesh or your C-QUR™ Mesh hernia repair.

i. The documents are attached_____[OR] I have no documents _____

SWORN DECLARATION

Plaintiff,_____, deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Amended Plaintiff Profile Form is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in this Amended Plaintiff Profile Form to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Amended Plaintiff Profile Form.

_____ _____

Date Signature of Plaintiff

SWORN DECLARATION

Consortium Plaintiff,_____, deposes and states as follows:

I declare under penalty of perjury that all of the information provided in this Amended Plaintiff Profile Form is true and correct to the best of my knowledge, information and belief; I have supplied all the documents requested in this Amended Plaintiff Profile Form to the extent that such documents are in my possession, custody, or control; and I have supplied the records authorizations requested in and attached to this Amended Plaintiff Profile Form.

_____ _____

Date Signature of Consortium Plaintiff

EXHIBIT B

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

TO: _____

Patient Name: _____

DOB: _____

SSN: _____

I, _____, hereby authorize you to release and furnish to: Litigation Management Inc. ("LMI"), 6000 Parkland Blvd., Mayfield Hts., OH 44124) COPIES ONLY of the following information:

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

1. To my medical provider: this authorization is being forwarded by, or on behalf of, attorneys for the parties to civil litigation. This authorization is construed to permit agents or designees of LMI and/or the parties to copy, inspect and review any and all such records.

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

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to LMI at the above address. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon resolution of the litigation, through and including any appellate disposition.

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

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

Print Name: _____(plaintiff/representative)

Signature:_____ _____

Date

1.

AUTHORIZATION AND CONSENT TO RELEASE PSYCHOTHERAPY NOTES

Name of Individual: _____

Social Security Number: _____

Date of Birth: _____

Provider Name: _____

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

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

Social Security Administration; and

Department of the Treasury/Internal Revenue Service;

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

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

The undersigned individual herby authorizes each entity included in any of the above categories to furnish and disclose to Litigation Management, Inc. ("LMI") 6000 Parkland Boulevard, Mayfield Heights, OH 44124 and its authorized representatives, with true and correct copies of all "psychotherapy notes", as such term is defined by the Health Insurance Portability and Accountability Act, 45 CPR §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 concerning C-Qur™ hernia mesh.

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

- The undersigned individual is hereby notified and acknowledges that he or she may revoke this authorization by providing written notice to either Litigation Management Inc. (6000 Parkland Boulevard, 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 redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- The undersigned is hereby notified that he/she is aware that any and all protected health information disclosed and furnished to LMI, pursuant to this authorization will be shared with any and all of the attorneys for the parties in the C-Qur™ hernia mesh litigation and is subject to redisclosure by the recipient for the purposes of this litigation in a manner that will not be protected by the Standards for the Privacy of Individually Identifiable Health Information contained in the HIPAA regulations (45 CFR §§164.500-164.534).

- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until the later of: (i) the date of settlement or final disposition of undersigned's Q-Qur™ hernia mesh litigation.

I have carefully read and understand the above and do hereby expressly and voluntarily authorize the disclosure of all of my above information to Litigation Management, Inc. 6000 Parkland Boulevard, Mayfield Heights, OH 44124, and its authorized representatives, by any entities included in the categories listed above.

Date:_____ _____

Signature of Individual or Individual's Representative

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

_____

Relationship of Representative to Individual (If applicable) _____

_____

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

AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of all school records including, but not limited to, test results, test scores, report cards, or other school grading material, attendance records, physicals and other health-related, including but not limited to any physicians, nursing or allied health professional reports, records or notes, which may be in your possession.

_____
Name of Student

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

You are authorized to release the above records to Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124 who have agreed to pay reasonable charges made by you to supply copies of such records.

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

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

Date:_____ _____
Student/Name

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508
EMPLOYMENT AUTHORIZATION

TO: _____
Name of Employer

_____
Address, City State and Zip Code

RE: Employee Name:_____aka _____

Date of Birth:_____Social Security Number:_____

Address: _____

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

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

I authorize you to release the information to; Litigation Management Inc., 6000 Parkland Boulevard, Mayfield Heights, OH 44124.

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

I acknowledge the right to revoke this authorization by writing to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the

entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires upon the resolution of my litigation, through and including any appellate disposition, concerning C-Qur™ hernia mesh.

_____

Signature of Employee or Personal Representative

_____

Name of Employee or Personal Representative

_____

Date

_____

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

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

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

_____
Name of Insured

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

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter, who have agreed to pay reasonable charges made by you to supply copies of such records: Litigation Management Inc. (6000 Parkland Boulevard, Mayfield Heights, OH 44124.

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

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

_____ _____
Name/Signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript 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-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

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 transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

- **a** **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐
- **b** **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐
- **c** **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2016	12 / 31 / 2015	12 / 31 / 2014	12 / 31 / 2013

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 information 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-T 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-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
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OMB No. 1545-1872

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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 transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

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- **b** **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐
- **c** **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2012	12 / 31 / 2011	12 / 31 / 2010	12 / 31 / 2009

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 information 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-T 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-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

Form **4506-T**
(July 2017)
Department of the Treasury
Internal Revenue Service

Request for Transcript 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-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

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 transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

12 / 31 / 2008	12 / 31 / 2007	12 / 31 / 2006	/ /

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 information 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-T 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-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) | Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** | Date

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

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

TO: Social Security Administration

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

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

***NAME OF PERSON OR ORGANIZATION:**

LITIGATION MANAGEMENT INC.

***ADDRESS OF PERSON OR ORGANIZATION:**

6000 PARKLAND BOULEVARD

MAYFIELD HEIGHTS, OHIO 44124

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

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 2007 to date 2017
5. ☒ My Medicare entitlement from date 2007 to date 2017
6. ☒ Medical records from my claims folder(s) from date 2007 to date 2017

   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.)

   CONSULTATIVE EXAMS, AWARD/DENIAL NOTICES, BENEFIT APPLICATIONS, APPEALS, QUESTIONNAIRES, DOCTOR REPORTS, DETERMINATIONS

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)

Standard Form 180 (Rev. 11/2015) (Page 1)
Prescribed by NARA (36 CFR 1233.18 (d))

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 04/30/2018

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE	-			☐	☐	
b. RESERVE	-			☐	☐	
c. STATE NATIONAL GUARD	-			☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - ***MUST** provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☑ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____

This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.

An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☑ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient)** the FACILITY NAME and DATE (month and year) for EACH admission **MUST** be provided:* _____

_____

☐ **Other** (Specify): _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☑ Other (explain)

Explain here: LITIGATION REQUEST

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: LITIGATION MANAGEMENT INC.

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN ***(MUST submit Proof of Death.** See item 2a on instruction sheet.)*

\-

(Relationship to deceased veteran)

☐ I am the VETERAN'S LEGAL GUARDIAN ***(MUST submit copy of Court Appointment)*** or AUTHORIZED REPRESENTATIVE ***(MUST submit copy of Authorization Letter or Power of Attorney)***

☑ OTHER DOCUMENT COLLECTION COMPANY

(Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

LITIGATION MANAGEMENT INC.

Name

6000 PARKLAND BOULEVARD

Street Apt.

MAYFIELD HEIGHTS OH 44124

City State Zip Code

* This form is available at ***http://www.archives.gov/veterans/military-service-records/standard-form-180.html*** on the National Archives and Records Administration (NARA) web site. *

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print **Date**

Daytime phone Fax Number

Email address

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1 Air Force Personnel Center
HQ AFPC/DPSIRP
550 C Street West, Suite 19
Randolph AFB, TX 78150-4721

2 Air Reserve Personnel Center
Records Management Branch (DPTSC)
18420 E. Silver Creek Avenue
Building 390 MS 68
Buckley AFB, CO 80011

3 Commander, Personnel Service Center
(BOPS-C-MR) MS7200
US Coast Guard
2703 Martin Luther King Jr Ave SE
Washington, DC 20593-7200
MR_CustomerService@uscg.mil

4 Headquarters U.S. Marine Corps
Manpower Management Records & Performance
(MMRP-10)
2008 Elliot Road
Quantico, VA 22134-5030

5 Marine Forces Reserve
2000 Opelousas Avenue
New Orleans, LA 70146-5400

6 National Archives & Records Administration
Research Services (RDT1R)
700 Pennsylvania Avenue NW
Washington, DC 20408-0001

7 US Army Human Resources Command's web page:
https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents
or 1-888-ARMYHRC (1-888-276-9472)

8 Navy Medicine Records Activity (NMRA)
BUMED Detachment St. Louis
4300 Goodfellow Boulevard, Building 103
St. Louis, MO 63120

9 AMEDD Record Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

10 Navy Personnel Command (PERS-313)
5720 Integrity Drive
Millington, TN 38055-3120

11 Department of Veterans Affairs
Records Management Center
ATTN: Release of Information
P.O. Box 5020
St. Louis, MO 63115-5020

12 Division of Commissioned Corps Officer Support
ATTN: Records Officer
1101 Wooton Parkway, Plaza Level, Suite 100
Rockville, MD 20852

13 AF STR Processing Center
ATTN: Release of Information
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

14 National Personnel Records Center
(Military Personnel Records)
1 Archives Drive
St. Louis, MO 63138-1002

*e*VetRecs:
http://www.archives.gov/veterans/military-service-records/