December 11, 2017

CLAIM FORM

THE PENSACOLA JAIL EXPLOSION SETTLEMENT
ATTN: ED GENTLE, SETTLEMENT ADMINISTRATOR
SUITE 100
501 RIVERCHASE PARKWAY EAST
BIRMINGHAM, ALABAMA 35244
1-205-716-3000
Pensacolasettlement@gtandslaw.com

CONFIDENTIAL
[CLAIMANT NAME]
[FIRM NAME C/O ATTORNEY]
[ADDRESS]
[ADDRESS]

COMPLETE ONE CLAIM FORM PER PERSON
YOU MUST MAIL OR OTHERWISE SUBMIT YOUR COMPLETED CLAIM FORM (WITH ALL SUPPORTING DOCUMENTS) BY MARCH 10, 2018 TO HAVE YOUR CLAIM REVIEWED.

INTRODUCTION.

On April 29-30, 2014, there was a flood, explosion, fire and evacuation at the Escambia County Central Booking and Detention Facility (the "CBDF") in Pensacola, Florida (the "Pensacola Jail Explosion" or the "Explosion"). Records show that approximately 668 people, constituting the Settlement Class, were present at the scene of the Explosion. Note: The phrase, Explosion, covers this entire event, including flooding, fire, explosion and evacuation, and not just the explosion, itself.

By December 15, 2015, 448 Claimants had hired Law Firms to represent them in connection with the Explosion and are called Represented Claimants, and the other 220 Claimants are called Pro Se Claimants. According to our records, [you are represented by _____.] [You are a Pro Se Claimant.] Represented Claimants are encouraged to discuss this proposed Settlement with the Law Firm representing them and Pro Se Claimants are encouraged to discuss this proposed Settlement with Robert Heath, Esq., a local Pensacola attorney engaged by the proposed Settlement with the authority of the Court to help you prepare and submit your claim. The contact information for your Law Firm, if you are represented, or the Lawyer advising Pro Se Claimants, if you are not, is provided at the end of this form.

You are being provided this Claim Form to apply for monetary benefits under a proposed Settlement with A.E. New, Jr., Inc., BITCO (as defined herein), Alliance Laundry Holdings, LLC, Sentry Insurance Co., The City of Pensacola d/b/a Pensacola Energy, Caldwell Associates

Architects, Inc., Atlantic Specialty Insurance Co., Coin Laundry Equipment Co., Inc., Certain Underwriters at Lloyd's, London, Escambia County, Florida, Columbia Casualty Co., Great American Excess & Surplus Co., Futch Design Associates, Inc., AXIS Surplus Insurance Co., Glaze Communications, H.M. Yonge & Associates, Inc., Liberty International Underwriters, Klocke and Associates, Inc., XL Specialty Insurance Co., Premier Engineering Group, LLC, AXIS Insurance Co., Rebol-Battle & Associates, Landmark American Insurance Company, SEMCO Inc., and Southern-Owners, Insurance Co., and Associated Electric and Gas Services, Ltd. (collectively the "Defendants").

WHY YOUR CASE NEEDS TO SETTLE.

In preparing this case and in negotiating this potential Settlement, the Law Firms conducted substantial research and some Represented Claimants have filed lawsuits. The Defendants are also represented by able counsel, and will vigorously fight these and all additional lawsuits about the Explosion, if this case does not settle. In reaching a potential Settlement, the Defendants have agreed to pay insurance coverage, totaling approximately $17,500,000*, **but only if** all approximately 668 Claimants agree to the Settlement. This amount includes ALL the insurance coverage of two of the Defendants, and a large percent of the coverage for ALL Defendants. We believe that the Settlement offer described below is fair and we recommend that you accept it. Of this amount, $2,520,000 (14.4%) is designated to be paid to the approximately 610 Inmates only, in connection with their civil rights claims, and the additional $14,980,000 (85.6%) is available to pay all Claims, including those of First Responders, Employees and Inmates. These two separate amounts are referred to hereinafter as the "Inmate Account" and the "All Claimants Account", respectively. See Attachment 1, explaining the compromise that led to the creation of these two accounts.

THE SETTLEMENT OFFER, LEGAL FEES AND EXPENSES AND PROPOSED PERSONAL INJURY PAYMENT GRID.

Under the terms of the Settlement Agreement posted on our website, the Defendants have agreed to pay approximately $17,500,000* to resolve the Claims of all approximately 668 Claimants, including Your Case. Of this amount, $2,520,000 (14.4%) is designated to be paid to the approximately 610 Inmates only, in connection with their civil rights claims, and the additional $14,980,000 (85.6%) is available to pay all Claims, including those of First Responders, Employees and Inmates. These two separate amounts are referred to hereinafter as the "Inmate Account" and the "All Claimants Account", respectively. First Responders and Employees will therefore be paid entirely from the All Claimants Account. Inmates will be paid from the All Claimants Account and the Inmate Account. The legal fees and expenses and the estimated total amount to be paid for personal injury claims of the approximately 668 Claimants,

*This insurance coverage includes defense costs. If this case doesn't settle, the amount available to pay claims will drop. $17,500,000 is the MAXIMUM amount of the Settlement, as some of the insurance policies are eroding due to the payment of legal fees. The actual estimated amount is $17,642,000, and was announced by the Defendants at the Preliminary Approval Hearing, and may continue to erode due to additional payment of legal fees. Therefore, the $17,500,000 amount is a good estimate of what will be available at the time of your payment.

including you, but excluding the Gravely Injured Claimants (whose legal fees and expenses are paid from their recoveries described below), are summarized in Attachment 1. Represented and Pro Se Claimants will be scored under the same grid. Attachment 1 provides for payment to the Law Firms of their fees and expenses due under written contracts with the Represented Claimants and for the payment of the fees and expenses of the attorney hired by the proposed Settlement to provide legal advice to the Pro Se Claimants. Any moneys remaining after the payment of these fees and expenses will be paid ratably to all Claimants, other than the three Gravely Injured Claimants described below.

To apply for a money recovery in connection with the Explosion under the proposed Settlement, described below, and to have your Claim scored, YOU MUST COMPLETE THIS CLAIM FORM and its Attachments.

SECTION A – CLAIMANT INFORMATION

_____

Claimant Name (Last, First, Middle)

_____

Street Address

_____ _____ _____

City State Zip Code

I was at the scene of the Central Booking and Detention Facility of Escambia County, in Pensacola, Florida (the "CBDF") when the Explosion occurred.

I was (check the one that applies):

- ☐ An Inmate
- ☐ An Employee
- ☐ A First Responder

_____ _____

Telephone Number E-mail Address

_____ _____/_____/_____

Social Security Number/Federal Tax Identification Number Date of Birth (Month, Day, Year)

_____

Gender (Male or Female)

In addition to completing this Claim Form, please complete:
(i) the W-9 in Attachment 4;
(ii) the attached two lien forms in Attachments 5 and 6; and
(iii) the attached Declaration of Assent, Release and Indemnity in Attachment 7.

THE SETTLEMENT ADMINISTRATOR WILL HOLD THESE MATERIALS IN ESCROW PENDING YOUR DECISION ON WHETHER TO ACCEPT THE SETTLEMENT BASED UPON YOUR CLAIM FORM SCORE AND THE AMOUNT YOU ARE CONSEQUENTLY OFFERED IN THE PROPOSED CLAIMANT SCORING AGREEMENT PROVIDED TO YOU BY THE SETTLEMENT ADMINISTRATOR.

SECTION B – DECLARATION OF MEDICARE/MEDICAID STATUS

1. Are you a Medicare Recipient? Yes No

If yes, please attach a copy of your Medicare ID Card, and indicate the amount(s) you received from Medicare in connection with injuries you claim resulted from the Explosion.

2. Are you a Medicaid Recipient? Yes No

If yes, please attach a copy of your Medicaid ID Card, and list all states from which you have received Medicaid benefits since January 1, 2014 on the line below.

_____

3. Are you currently a Medicare or Medicaid Recipient, but were not a Medicare/Medicaid (circle one or both) recipient at the time of the Explosion (April 29-30, 2014)?
Yes No

SECTION C – THE SETTLEMENT MATRIX

(1) Claimant Categories.

There are 2 types of Claimants: (A) 3 Gravely Injured Claimants; and (B) approximately 665 Additional Claimants, together with anyone who was married to such a Claimant at the time of the Explosion; in the case of a deceased Claimant, the wrongful death beneficiaries or heirs of such a Claimant; or anyone who is related to the Claimant and has a Claim through the Claimant due to such relationship. Of the

Additional Claimants at the Explosion, 608 were Inmates, approximately 37 were Jail Employees and approximately 20 were First Responders. All the Additional Claimants have the same proposed matrix categories, described below. Spouses, wrongful death beneficiaries or heirs, or other relatives with a Claim through the Claimants (the "Other Claimants") at the scene of the Explosion are required to sign the Claim Form with such Claimants, although Other Claimants will not receive a payment.

a. Possible $250 Advance Payment.

After final approval of the Settlement, and the funding of the Settlement by the Defendants, each Claimant (but not an Other Claimant) may receive a $250 advance payment upon completing his or her Claim Form and all related documentation. The Advance Payment shall be remitted by the Settlement Administrator to all such Class Members who have successfully completed a Claim Form and taken all other steps to qualify for this Settlement immediately upon the Settlement Amount, as defined in Section 1.3 of the Settlement Agreement, which is found on our website, being paid to the Section 468B Qualified Settlement Fund as contemplated herein, provided, however, that the Settlement Administrator has first obtained and provided to the Parties to this Settlement reasonably acceptable written confirmation from the Florida Department of Revenue as to child support obligations, Florida Agency for Health Care Administration or its designee with respect to Medicaid obligations, and the Florida League of Cities with respect to its claims, Clerk of the Escambia County Circuit Court as to restitution that they do not object to the Advance Payment and waive any claims from a Settlement Class Member receiving such Advance

Payment or Defendants and Insurers. The Settlement Administrator shall not make any payment from the Settlement Amount to any Settlement Class Member until all Liens upon said Settlement Class Member's recovery have been resolved and the Settlement Administrator has provided Defendants and Insurers with releases or other reasonable proof of the satisfaction of the Liens reasonably satisfactory to Defendants and Insurers ("the Claimant Lien Vetting Package"). Each Defendant and Insurer shall have ten (10) days from its receipt of such written release or satisfaction of Lien materials to advise the Settlement Administrator of any objections to the sufficiency of the release or Lien Satisfaction materials. Any dispute over the sufficiency of a Lien satisfaction and/or release shall be submitted to the Court for resolution. The Lienholder shall be made a party to such a proceeding in the event it will not participate voluntarily. The Settlement Administrator, in collaboration with the Parties shall use due diligence to determine all reasonably accessible Lienholders with respect to each Claimant. Also, only Claimants who are, prior to an Advance Payment being made, confirmed by Medicare in writing to be Medicare ineligible may receive the Advance Payment. For Claimants with a Lien established by court order, reasonably acceptable consent shall be consent by authorized counsel for the agency having authority to enforce the Lien. The Settlement Administrator shall obtain the information necessary to determine who is Medicare eligible prior to making an Advance Payment. To treat all Class Members fairly, those Class Members not eligible to receive a $250 Advance Payment under the foregoing conditions will have the $250 amount added to their

recovery under the Settlement, to be paid in accordance with Paragraph 9.2 and other provisions of the Settlement Agreement, which is found on our website.

(2) Claimant Category Workshops.

a. Workshop Exempt Claimants.

This portion of the proposed matrix does not apply to the Gravely Injured Claimants, described in Paragraph (3) below, who have already been identified and scored and their payment amount has been determined. It also does not apply to First Responders deciding to file their claim for the First Responder Category in Paragraph (4) below, as this request will automatically be granted for any First Responder in this category upon the Claimant's completion of the Claim Form, with the First Responder payment amount already being determined. It also does not apply to Inmates or Employees filing a claim under Category One in Paragraph (4) below, as such claims will automatically be granted upon the Claimant's completion of the Claim Form, with the payment amount for Category One Claims under the Matrix already being determined. For a Claimant who is a Gravely Injured Claimant, a First Responder (filing in the First Responder Category), an Inmate (filing in Category One) or an Employee (filing in Category One) described in this paragraph, no workshop is required. Note that, if you are a Claimant who was at the scene of the Explosion and you have one or more Other Claimants, they must also sign the Claim Form.

b. Workshop Claimants.

All Claimants not described in Paragraph (2)a. above, are invited to have their Claim graded in a workshop to determine its appropriate category, prior to

their deciding whether to consent to the potential Settlement. Approximately 452 Claimants already went through this workshop process, and do not have to repeat it, but with the same workshop process to be used for all Claimants. First Responders filing a Claim under Categories One through Seven, and Employees and Inmates filing a Claim under Categories Two through Seven will have their Claim reviewed by the Settlement Administrator, subject to a confidentiality agreement to protect your individual and private medical and other Claim information.

Claimants whose Claim is being reviewed in the workshop and their counsel are invited to attend the workshop at which the Claim will be reviewed, and the lawyers representing the other Claimants in the case will also be invited.

The purpose of the workshop is to carefully review each Claim so as to determine the Claim's appropriate category, in order to be as fair as possible and as consistent as possible for all Claims. The descriptions and estimated payments for each category of Claimant are described below:

SOME CLAIMANTS LOST PERSONAL EFFECTS OR OTHER PROPERTY AS A RESULT OF THE EXPLOSION, AND THE BELOW AWARDS COVER THIS LOSS ALSO.

(3) Gravely Injured Claimants.

These 3 Claimants were at the Explosion and had catastrophic injury resulting from the Explosion, with two being killed and one becoming a paraplegic for life. Their injuries are described in Attachment 3. One deceased

Claimant had 5 survivors and one deceased Claimant had 1 survivor. If you are a Gravely Injured Claimant, the box next to your award is checked.

The proposed awards to the three Gravely Injured Claimants are:

☐	(A) Paraplegic Employee Claimant	$4,625,000 (Paid from the All Claimants Account described below)
☐	(B) Deceased Inmate Claimant with 5 Survivors	$2,137,500(85.6% or $1,829,700 paid from the All Claimants Account described below and 14.4% or $307,800 paid from the Inmate Account described below)**
☐	(C) Deceased Inmate Claimant with 1 Survivor	$1,737,500(85.6% or $1,487,300 paid from the All Claimants Account described below and 14.4% or $250,200 paid from the Inmate Account described below)***
	TOTAL:	$8,500,000

These total amounts for the Gravely Injured Claimants will be reduced by their $250 each advance payments and their ratable share of Claims Administrator fees ($129,589). The remaining payments to the Gravely Injured Claimants are $4,554,239, $2,104,662 and $1,710,760, respectively, before payment of their legal fees and expenses which will be deducted from these amounts, or a total of $8,369,661. Two of these Claimants were Inmates, and one is an Employee.

** 85.6% from the All Claimants Account and 14.4% from the Inmate Account.

After the above payments to the Gravely Injured Claimants, the balance of the two accounts is as follows: $7,038,000 in the All Claimants Account*** and $1,962,000 in the Inmate Account****, or a total of $9,000,000.

Exhibit F describes the grave injuries of each of these 3 Claimants. If this case does not settle, the value of their claims may exceed $17,500,000, and a judgment in favor of one or more of the Gravely Injured Claimants may leave no moneys for the other Claimants. This is another reason this case needs to settle.

☐ **(4) Additional Claimants.**

If you are an Additional Claimant, the box to the upper left is checked.

There are an estimated 665 Additional Claimants, who were at the Explosion, including an estimated 608 Inmates, an estimated 37 Jail Employees and an estimated 20 First Responders, who are scored under the same Proposed Matrix. In this Claim Form, if we show that a Claimant is an Additional Claimant, the Additional Claimant box will be checked above.

Each Additional Claimant is in one of the following 8 categories, and may, also, qualify for the Extraordinary Damages Category, described below. In this Claim Form, the Claimant is asked to **CHECK BELOW THE ONE BOX THAT BEST APPLIES TO THE HIGHEST CATEGORY** (from one to seven) **THAT APPLIES TO YOU**

*** This balance in the All Claimants Account is calculated as follows: $14,980,000 (for all Settlement Claims) minus $4,625,000 (to pay Gravely Injured Claimant (A)) minus $1,829,700 (to pay Gravely Injured Claimant (B)) minus $1,487,300 (to pay Gravely Injured Claimant (C)) = $7,038,000.

**** This balance in the Inmate Account is calculated as follows: $2,520,000 (Settlement for Inmate Civil Rights Claims) minus $307,800 (to pay Gravely Injured Claimant (B)) minus $250,200 (to pay Gravely Injured Claimant (C)) = $1,962,000.

(no more than one box), and only also check the Extraordinary Damages Category if it applies to you. **NOTE: THE FINAL DETERMINATION OF THE CLAIMANT'S CATEGORY WILL BE MADE BY THE SETTLEMENT ADMINISTRATOR, BASED ON THE PROOF PROVIDED.**

The Claimant shall provide all written **PROOF** of his or her injury (required for First Responders for Categories One through Seven and for Inmates and Employees for Categories Two through Seven), which can include medical records, medical bills, mental therapy records, and/or a written description of your injury, by you, or a witness or a medical provider. First Responder Category or Category One Claimants (who are not First Responders) are not required to provide written proof unless they also make a claim for Extraordinary Damages, described below. Below, we ask for specific additional information for some of the Categories.

PROOF MUST EXIST BY THE DATE OF THE SETTLEMENT PRELIMINARY APPROVAL ORDER. CLAIMANT SICKNESS WILL BE GRADED AS OF THE DATE OF THE SETTLEMENT PRELIMINARY APPROVAL ORDER. THERE WILL BE NO COMPENSATION TO TAKE INTO ACCOUNT A CLAIMANT POSSIBLY OR ACTUALLY GETTING SICKER LATER.

☐ **First Responder Category - At Scene of Explosion and Not Injured.**

You were a First Responder. You were at the scene of the Explosion and experienced none of the physical or mental injuries described below for the additional categories. NO WRITTEN PROOF IS REQUIRED FOR THIS CATEGORY.

☐ **Category One - Minor Physical Injury.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. As a result of the Explosion, you suffered no bodily injury other than minor cuts or bruises, and had no follow-up medical care after 1 week from the date of the Explosion. You had no broken bones. You received no treatment for any mental injury resulting from the Explosion after 1 month from the date of the Explosion. NO WRITTEN PROOF FOR INMATES OR EMPLOYEES IS REQUIRED FOR THIS CATEGORY. HOWEVER, A FIRST RESPONDER MUST PROVIDE PROOF OF MINOR PHYSICAL INJURY. NOTE: IF YOU ARE IN THIS CATEGORY BUT WERE TAKEN TO THE EMERGENCY ROOM AS A RESULT OF THE EXPLOSION, YOU MUST PROVIDE PROOF AND CAN APPLY FOR AN EMERGENCY ROOM ENHANCEMENT OF $1,000 UNDER THE EXTRAORDINARY DAMAGES FUND DESCRIBED BELOW. We estimate that there are between 10 and 20 such Claimants.

☐ **Category Two - No Longer Treated for Physical Injury After 1 Month or Mental Injury After 3 Months. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or

First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: As a result of the Fire, you had lacerations, bruises or required breathing treatment, and received emergency room or emergency care. You received medical treatment for more than 1 week but not after 1 month from the date of the Fire. You had no broken bones.

(ii) Mental Injury: As a result of the Fire, you had panic reactions, mental confusion, depression, disassociation, severe insomnia, suspiciousness, and/or being unable to manage basic self care, work and relationship activities, or other major psychological conditions. You received appropriate treatment justified by your symptoms, or can document that you requested such treatment within 6 months after the Fire, or were advised in writing by a psychologist, mental health therapist, psychiatrist or other professional to obtain treatment within 6 months after the Fire, which may have included removal from the scene of the trauma, use of medication for immediate relief of grief, anxiety and insomnia, and brief support of psychotherapy provided in the context of crisis intervention, or other appropriate treatment justified by your symptoms. You received treatment for any mental injury resulting from the Fire more than 1 month but not after 3 months from the date you first received treatment. Please provide all applicable medical, psychologist, mental therapist or psychiatric or other professional documentation or bills. **(Mental Condition No Longer Treated)**.

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **Category Three - Physical Injury Without Surgery And/Or Mental Treatment for Less Than 6 Months. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: As a result of the Explosion, you had no surgeries but you received or requested treatment for your injuries from a health care professional, which may have been a chiropractor, appropriate for your injuries, which may have consisted of broken bones of the toes, fingers or one rib, but not of the larger or more important bones or bone groups. Please provide your medical bills, which may include chiropractic bills.

(ii) Mental Injury: As a result of the Explosion, you have experienced symptoms of Post-Traumatic Stress Disorder ("PTSD"), or other major psychological conditions, including persistent re-experiencing of the traumatic event, depression, avoidance of stimuli associated with the trauma, emotional numbing, and/or symptoms of increased arousal. You have received group, psychodynamic, cognitive-behavioral, or pharmacological therapy or combination approaches to your therapy, or other appropriate treatment justified by your symptoms, and can document that you requested such treatment within 6 months after the Explosion, or were advised in writing by a psychologist, mental health therapist,

psychiatrist or other professional to obtain such treatment within 6 months after the Explosion. You received treatment for any mental injury resulting from the Explosion for more than 3 months but less than 6 months after you first received treatment. Please provide all applicable medical, psychologist, mental therapist or psychiatric or other professional documentation or bills. **(Mental Condition No Longer Treated)**

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **Category Four - Continued Complex Treatment for Physical Injury and/or for Mental Injury for Less Than 12 Months. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: As a result of the Explosion, you had major broken bones such as a hand, ankle, arm, leg, or two or more ribs. You had no surgery or minor surgery and had pain management or orthopedic consultation, or have a doctor's written opinion that such pain management or orthopedic consultation is required. The referral to or treatment with pain management or orthopedic must be supported by reasonably consistent care and treatment appropriate for the conditions so treated caused by the Explosion demonstrated by appropriate medical records. Please describe the type of pain management you had.

(ii) Mental Injury: As a result of the Explosion, you have PTSD or other major psychological condition. These conditions are usually associated with at least one other major psychiatric disorder such as depression, alcohol or substance abuse, panic disorder and other anxiety disorders. You received appropriate treatment justified by your symptoms, and can document that you requested such treatment within 6 months after the Explosion, or were advised in writing by a psychologist, mental health therapist, psychiatrist or other professional to obtain such treatment within 6 months after the Explosion. You received treatment for mental injury from the Explosion for more than 6 months but for less than 12 months from the date you first received treatment. Please provide all applicable medical, psychologist, mental therapist or psychiatric or other professional documentation or bills. **(Mental Condition No Longer Treated)**

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **Category Five - Non-Severe Surgery and/or Post-Concussive Syndrome and/or Mental Injury Treatment for Less Than 2 Years. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: As a result of the Explosion, you had surgery of the knee, shoulder or any part of the body other than the spine, or you have a

doctor's written opinion that such surgery is required, or you had brain or other head injury. The referral for surgery must be supported by reasonably consistent care and treatment appropriate for the conditions so treated caused by the Explosion demonstrated by appropriate medical records. As a result of the severe brain or head injury, you had Post Concussive Syndrome, defined as a minor traumatic brain injury with at least three or more of the following symptoms: fatigue, sleep disturbance, headaches, dizziness, irritability, affective disturbance, apathy or personality change lasting for months after the concussion. Please provide your medical bills, and describe the type of surgery.

(ii) Mental Injury: As a result of the Explosion, you have PTSD or other major psychological condition. These conditions are usually associated with at least one other major psychiatric disorder such as depression, alcohol or substance abuse, panic disorder and other anxiety disorders. You have received group, psychodynamic, cognitive-behavioral, or pharmacological therapy or combination approaches to your therapy, or other appropriate treatment justified by your symptoms, and can document that you requested such treatment within 6 months after the Explosion, or were advised in writing by a psychologist, mental health therapist, psychiatrist or other professional to obtain such treatment within 6 months after the Explosion. You received treatment for mental injury from the Explosion for more than 12 months but for less than 2 years from the date

you first received treatment. Please provide all applicable medical, neurological, psychologist, mental therapist or psychiatric or other professional documentation or bills. **(Mental Condition No Longer Treated)**

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **Category Six - Spinal Surgery or Other Severe Surgery and/or Prolonged Neuropsychological Impairments After Surgery and/or PTSD or Other Major Psychological Condition That is Still Being Treated. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim.**

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. As a result of the Explosion, you had spinal surgery or other severe surgery, or a written doctor's opinion that such surgery is required, or you had severe brain or other head injury resulting in prolonged neuropsychological impairments affecting your cognitive function, motor function and sensation and emotion, but you are not unable to work, and do not have material loss of bodily function. The need for surgery must be supported by reasonably consistent care and treatment appropriate for the conditions so treated caused by the Explosion demonstrated by appropriate medical records. For

surgery, please provide your medical bills, describe the surgery and indicate what vertebra(e) were involved, and indicate if future surgeries are required.

(ii) Mental Injury: As a result of the Explosion, you have PTSD or other major psychological condition usually associated with at least one other major psychiatric disorder such as depression, alcohol or substance abuse, panic disorder and other anxiety disorders. You have received and are receiving group, psychodynamic, cognitive-behavioral, or pharmacological therapy or combination approaches to your therapy, or other appropriate treatment justified by your symptoms, and can document that you requested such treatment within 6 months after the Explosion, or were advised in writing by a psychologist, mental health therapist, psychiatrist or other professional to obtain such treatment within 6 months after the Explosion. The PTSD or other major psychological condition is still being treated, but you are able to work and do not have significant loss of bodily function. Please provide evidence of any mental disorder resulting from the Explosion and any treatment thereof. Please provide all applicable medical, neurological, psychologist, mental therapist or psychiatric or other professional documentation or bills. **(Medical condition is still being treated)**

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **Category Seven - So Severely Physically, Neurologically and/or Mentally Impacted by the Explosion That Claimant is Unable to Work or Have**

Material Loss of Bodily Function or Permanent Total Disability. Provide All Your Medical Records and Medical Bills To Help Prove Your Claim. If You Claim Permanent Total Disability, a Written Vocational Expert Opinion is Required.

You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. You may qualify for this Category if Paragraphs (i) or (ii), or both apply.

(i) Physical Injury: You were inside the CBDF at the time of the Explosion, as an Inmate, a Jail Employee or First Responder. As a result of your physical, brain or head injury resulting from the Explosion, you are permanently totally disabled or have other extraordinary permanent injury or disability resulting in prolonged physical or neuropsychological impairments affecting your cognitive function, motor function and sensation and emotion, and you are unable to work or have significant loss of bodily function. Please provide proof of your permanent total disability. Please provide proof of any Workers Comp lien.

(ii) Mental Injury: As a result of the Explosion, you have PTSD or other major psychological condition. Such conditions are usually associated with at least one other major psychiatric disorder such as depression, alcohol or substance abuse, panic disorder and other anxiety disorders. You have received and are receiving group, psychodynamic, cognitive-behavioral, or pharmacological therapy or combination approaches to your therapy, or

other appropriate treatment justified by your symptoms, and can document that you requested such treatment within 6 months after the Explosion, or were advised in writing by a psychologist, mental health therapist, psychiatrist or other professional to obtain such treatment within 6 months after the Explosion. As a result of the ongoing PTSD or other major psychological condition resulting from the Explosion, you are unable to work or have significant loss of bodily function. Please provide evidence of any mental disorder resulting from the Explosion and any treatment thereof. Please provide all applicable medical, neurological, psychologist, mental therapist or psychiatric or other professional documentation or bills.

Please provide proof of Paragraphs (i) or (ii), or both.

☐ **EXTRAORDINARY DAMAGES OR CASE REPRESENTATION AWARDS FOR INMATES, EMPLOYEES OR FIRST RESPONDERS**

Some Claimants (i) filed the original Action (a "Representative Claimant") that helped the case settle (about 85 Claimants), (ii) are in Category One but were taken to the Emergency Room as a result of the Explosion (the "Emergency Room Enhancement"); and/or (iii) may have unusual injuries that merit an additional recovery not reflected in the above Categories. A Representative or Emergency Room Enhancement Claimant may apply for additional extraordinary damages. A total of $206,489, of which $176,754.58 is in the All Claimants Account and $29,734.42 is in the Inmate Account, is estimated to be available for these Extraordinary Damages.

These awards are for (i) the approximately 85 Claimants who filed the Action (the "Representative Claimants"); (ii) the approximately 10 to 20 Emergency Room Enhancement Claimants; and (iii) any Claimants with medical bills or other extraordinary damages not adequately compensated. Representative Claimants will each receive $1,323, Emergency Room Enhancement Claimants will each receive $1,000, and the other Extraordinary Damages Claimants will receive an amount that can be justified by their extraordinary damages, but limited to the amount in the Extraordinary Damages Account after payment to the Representative Claimants and Emergency Room Enhancement Claimants, and considering and all other such claims filed by Extraordinary Damages Claimants and after setting aside $50,000 as a "Discovery Reserve". As part of this Class Action, discovery may be conducted, and $50,000 is being set aside as a Discovery Reserve. If any of the Discovery Reserve funds remain after payment of discovery costs and expenses, those remaining funds would be made available for Extraordinary Damages Claimants.

Representative Claimants shall each be paid $1,323, with such Claimants who are Inmates being paid 85.6% from the All Claimants Account and 14.4% from the Inmate Account, and non-Inmate Representative Claimants being paid entirely from the All Claimants Account. Emergency Room Enhancement Claimants shall each be paid $1,000, with such Claimants who are Inmates being paid 85.6% from the All Claimants Account and 14.4% from the Inmate Account, and non-Inmate Representative Claimants being paid entirely from the All Claimants Account.

Other Extraordinary Damages Claimants will be paid as follows: For likewise situated Extraordinary Damages Claimants, non-Inmates shall receive approximately 85.6 cents for every dollar received by Inmates.

If you qualify for these Extraordinary Damages, please check the box above and provide written PROOF. Those qualifying for the Extraordinary Damages will be paid to the extent that monies are available. If the total amount of this Extraordinary Damages Payment is not distributed, it will be paid ratably to all the Additional Claimants, subject to the All Claimants Account/Inmate Account distributions split described in Footnote*****.

D. POSSIBLE ADDITIONAL CONDITIONS IF NOT ALL CLAIMANTS AGREE.

If not all Claimants agree to the Settlement, and if the termination thresholds in Section 10.3 of the Settlement Agreement are exceeded, the Defendants have the right to reject the Settlement. If some Claimants opt-out of the Settlement, the Settlement Administrator will use his best efforts to determine how the opt-out Claimants would score under the Matrix categories and the amount they would receive had they participated in the Settlement (and all related fees and expenses in Attachment 1), called the "Opt-Out Reserve." The Settlement Administrator will propose to the Defendants that they accept this amount as an adequate reserve to protect them from the opt-out Claimants' Claims respecting the Explosion. **However, the Defendants may also require that part of a Claimant's payment be held back or that the Claimant**

***** Allocation of Inmate payments is done as follows: 14.4% comes from the Inmates Account and 85.6% comes from the All Claimants Account.

indemnify them or make other demands of the Claimants (the "Additional Defendant Demands").

If Additional Defendant Demands are made, the Settlement Administrator will not go forward without the Settlement Administrator describing the Additional Defendant Demands to the Claimants, and getting your written permission to meet these demands.

E. ESTIMATED PAYMENT FOR EACH PROPOSED MATRIX CATEGORY.

The estimated value of the Gravely Injured Claimants is provided above for each Claimant. In making these estimates, we have assumed that all Claimants participate, to provide you what we believe to be the fairest estimate under the circumstances.

Some of the Law Firms and Robert Heath, Esq. for some of the Pro Se Claimants have surveyed how 452 of the approximately 665 Additional Claimants apparently fall in the foregoing 8 Categories. Based upon this sample of 452 of the approximately 665 Additional Claimants, we have extrapolated how the scores for the approximately 665 Claimants may be allocated among the 8 Categories in the following table, so as to provide you with the estimated value of your case. Based upon these assumptions, **THE TABLE BELOW ESTIMATES THE AMOUNT OF YOUR PAYMENT**, in addition to the $250 Advance Payment, with the value of a Claimant's case for each Category being shown in Column B below **(a Claimant could receive less or more depending on the final Claimant Categories for the approximately 665 Additional Claimants, and whether or not they all participate. This is our best estimate based upon the facts**

and circumstances now known.). The spreadsheets in Attachment 7 summarize our computations.

QUESTION: What if there is not enough money to pay all Claimants the estimated amounts under the following Grid?

ANSWER: The amounts paid to Claimants other than the Gravely Injured Claimants, the First Responder Category and Category One will be ratably reduced. That is, if these estimates are high (by projecting that there are fewer Claimants in the upper Categories than there are), you will receive less, using the following equation: Claimant A's recovery will be reduced by the shortfall (the amount that would be needed to pay the grid estimates below) times Claimant A's recovery under the grid divided by the grid recoveries of all Claimants (including Claimant A) other than the Gravely Injured Claimants. For example, if, after calculation of all the Claims, the amount available to pay all Claims is short by $100,000, with the grand total of all Claims paid under the following Grid equaling $5.6 Million, and Claimant A was due to receive $3,000 under the Grid, then Claimant A's recovery will be reduced by $100,000 / $5.6 Million x $3,000, or $53.57. Therefore, Claimant A's Claim will be reduced from $3,000 to $2,946.43.

QUESTION: What if there is more than enough money to pay all Claimants the estimated amounts under the following Grid?

ANSWER: The amounts paid to Claimants other than the Gravely Injured Claimants and the First Responder Category will be ratably increased. If these estimates are low

(by projecting that there are more Claimants in the upper Categories than there are), then the amount paid to Categories One through Seven (but not to the First Responder Category) will be ratably increased with this equation: Claimant A's additional payment equals Claimant A's recovery under the grid divided by the grid recoveries of all Claimants in all Categories (including Claimant A) other than the Gravely Injured Claimants and the First Responder Category times the amount of the surplus (the amount left over when the amounts computed below are paid). For example, if, after calculation of all the Claims, there is an additional $100,000 left over, with the grand total of all Claims equaling $5.5 Million, and Claimant A was due to receive $3,000 under the Grid, then Claimant A's recovery will be increased by $3,000 / $5.5 Million x $100,000, or $54.54. Therefore, Claimant A's Claim will be increased from $3,000 to $3,054.54.

THESE ESTIMATED PAYMENTS ARE AFTER LEGAL FEES AND EXPENSES ARE PAID, AND ARE THEREFORE NOT REDUCED BY LEGAL FEES AND EXPENSES.

	A Estimated Number Of Claimants In Category	B Estimated Amount You Will Receive	C Estimated Total Payments For Entire Category From The All Claimants Account	D Estimated Total Payments For Entire Category From the Inmates Account******
First Responder Category:	20 First Responders	$500(This amount is fixed)	$10,000	$0.00
Category One:	249 (240 Inmates and 9 Employees)	$1,200 For Employees and $1,530 for Inmates (There are no degree of physical or mental injury subcategories) (These amounts will not be decreased)	$298,800	$79,200
Category Two:	279 (266 Inmates and 13 Employees)	$2,700 For Employees and First Responders and $3,440 for Inmates (There are no degree of physical or mental injury subcategories)	$753,300	$196,840
Category Three:	46 (43 Inmates and 3 Employees)	$5,400 For Employees or First Responders and $6,870 for Inmates. (This is an average. This Category will be divided into 3 Subcategories: 1,2 and 3 based upon the severity of physical or mental Injury. Category 1will receive a score of 75, Category 2 will receive a score of 100, and Category 3 will receive a score of 125. We estimate that the lowest Subcategory will receive $4,050 for Employees and First Responders , and $5,152 for Inmates, the middle Subcategory will receive $5,400 for Employees and First Responders, and $6,870 for Inmates, and the upper Subcategory will receive $6,750 for Employees and First Responders and $8,588 for Inmates.)	$248,400	$63,210

***** Allocation of Inmate payments is done as follows: 14.4% comes from the Inmates Account and 85.6% comes from the All Claimants Account.

A	B	C	D
Estimated Number Of Claimants In Category	Estimated Amount You Will Receive	Estimated Total Payments For Entire Category From The All Claimants Account	Estimated Total Payments For Entire Category From the Inmates Account******
Category Four: 20 (19 Inmates and 1 Employees)	$12,000 For Employees or First Responders and and $15,420 for Inmates. (This is an average. This Category will be divided into 3 Subcategories: 1,2 and 3 based upon the severity of physical or mental Injury. Category 1will receive a score of 75, Category 2 will receive a score of 100, and Category 3 will receive a score of 125. We estimate that the lowest Subcategory Will receive $9,000 for Employees and First Responders , and $11,565 for Inmates, the middle Subcategory will receive $12,000 for Employees and First Responders, and $15,420 for Inmates, and the upper Subcategory will receive $15,000 for Employees and First Responders and $19,275 for Inmates.)	$240,000	$64,980
Category Five: 18 (16 Inmates and 2 Employees)	$24,000 For Employees or First Responders and and $30,870 for Inmates. (This is an average. This Category will be divided into 3 Subcategories: 1,2 and 3 based upon the severity of physical or mental Injury. Category 1will receive a score of 75, Category 2 will receive a score of 100, and Category 3 will receive a score of 125. We estimate that the lowest Subcategory Will receive $18,000 for Employees and First Responders , and $23,152 for Inmates, the middle Subcategory will receive $24,000 for Employees and First Responders, and $30,870 for Inmates, and the upper Subcategory will receive $30,000 for Employees and First Responders and $38,588 for Inmates.)	$432,000	$109,920

*****Allocation of Inmate payments is done as follows: 14.4% comes from the Inmates Account and 85.6% comes from the All Claimants Account.

	A Estimated Number Of Claimants In Category	B Estimated Amount You Will Receive	C Estimated Total Payments For Entire Category From The All Claimants Account	D Estimated Total Payments For Entire Category From the Inmates Account******
Category Six:	17 (16 Inmates and 1 Employees)	$60,600 For Employees or First Responders and and $69,600 for Inmates. (This is an average. This Category will be divided into 3 Subcategories: 1,2 and 3 based upon the severity of physical or mental Injury. Category 1will receive a score of 75, Category 2 will receive a score of 100, and Category 3 will receive a score of 125. We estimate that the lowest Subcategory will receive $45,450 for Employees and First Responders , and $52,200 for Inmates, the middle Subcategory will receive $60,600 for Employees and First Responders, and $69,600 for Inmates, and the upper Subcategory will receive $75,750 for Employees and First Responders and $87,000 for Inmates.)	$1,030,200	$144,000
Category Seven:	16 (8 Inmates and 8 Employees)	$100,000 For Employees or First Responders and and $114,850 for Inmates. (This is an average. This Category will be divided into 3 Subcategories: 1,2 and 3 based upon the severity of Injury. Category 1 will receive a score of 75, Category 2 will receive a score of 100, and Category 3 will receive a score of 125. We estimate that the lowest Subcategory will receive $75,000 for Employees and First Responders , and $86,137 for Inmates, the middle Subcategory will receive $100,000 for Employees and First Responders, and $114,850 for Inmates, and the upper Subcategory will receive $125,000 for Employees and First Responders and $143,563 for Inmates.)	$1,600,000	$118,800

*****Allocation of Inmate payments is done as follows: 14.4% comes from the Inmates Account and 85.6% comes from the All Claimants Account.

SECTION D – SUMMARY OF MATRIX PAYMENT COMPUTATIONS AND THE ESTIMATED DISTRIBUTION OF THE $17.5 MILLION.*****

The Matrix distribution computations are summarized in Attachment 4. Attachment 5 provides the estimated distribution of the $17.5 Million Settlement Amount, depicting, in addition to Claimant payments, gross settlement, legal fees and expenses account for Counsel for Individual Settlement Class Members other than the 3 Gravely Injured Claimants, and legal fees and expenses for independent Counsel advising the pro se Claimants.

SECTION E – PLEASE COMPLETE THIS SECTION TO APPLY FOR CONSIDERATION UNDER THE PROPOSED SETTLEMENT.

The Defendants may require 100% Settlement participation by all 668 Claimants for the Settlement to become effective. If you reject this Settlement, the Defendants may refuse to settle any of the 668 cases. Any delay by you in returning the enclosed documents or refusal to participate in the Settlement affects you and all other Class Members.

If you choose to accept this Settlement offer, you should carefully review all of the enclosed documents, and then do ALL of the following within 30 days of the date of this letter:

1. Please complete Sections A, B and C above, and complete, sign and have witnessed this Form where indicated below and return it to us;

2. Please provide any DOCUMENTS and/or PROOF that is required for your payment category checked in Section C above;

3. Please Complete and sign the enclosed Benefits Questionnaire and Release forms in Attachments 5 and 6 and return them to us;

4. Please complete and sign the W-9 in Attachment 4; and

*******$17.5 million is the MAXIMUM amount of the Settlement. Some of it represents eroding insurance policies, so that the total Settlement amount will be less than $17.5 million. The exact Settlement amount was announced by the Defendants at the Preliminary Approval Hearing and equals $17.642 Million, and may continue to erode due to payment of legal fees. Therefore, the $17,500,000 amount is a good estimate of what will be available at the time of your payment.

5. Please sign and return to us this completed Claim Form, the Benefit Questionnaire and Release forms in Attachments 5 and 6, and the W-9 in Attachment 4, and all supporting documents and/or proof to the Settlement Administrator.

6. Please complete and sign the Declaration of Assent, Release and Indemnity Agreement in Attachment 7. Put your name on the first line, and we will put the docket number on the Settlement line. Please sign and date at the bottom of page 6 and print your name on the top of page 7. Have your signature witnessed, with the witness signature, name and date to be at the top of page 7. If you were married at the time of the Explosion, your spouse needs to sign and be witnessed on page 7.

7. Note that ALL CLAIMANTS are required to have their spouse/domestic partner sign the Claim Form.

SECTION F - CLAIMANT SCORING AGREEMENT PROCESS

The Settlement Administrator will score the Claim Form, as soon as you complete it, and all of its Attachments, except for the Claimant Scoring Agreement, which will be provided to you later.

After the Settlement Administrator scores your Claim and all other Claims that are submitted, he will provide you with a proposed Claimant Scoring Agreement in the form of Attachment 9, providing you with your proposed score and the estimated payment that you are to receive, with supporting mathematical computations.

Upon receiving the proposed Claimant Scoring Agreement, you can agree to it by signing it, having it notarized, and returning it to the Settlement Administrator. Or, you can appeal the Settlement Administrator's determination of your score as follows.

If you wish to appeal the Settlement Administrator's determination of your score, within 35 days of receiving the proposed Claimant Scoring Agreement, you must submit a request to the Settlement Administrator for re-evaluation of the scoring as described in the Settlement Agreement on our website. The Settlement Administrator will complete the re-evaluation of first round scoring and will notify all Claimants of the results of the re-evaluation within 20 days following the 35-day deadline. If you still disagree with the re-evaluation, you may choose to opt-out or object. The deadline to opt-out or object is September 1, 2018 (265 days after the

effective date of the Preliminary Approval Order). The procedures of opting out or objecting to the Settlement are described in the Settlement Agreement and the Long-Notice Form, which are found on our website.

PLEASE SIGN THIS FORM BELOW AND HAVE YOUR SIGNATURE WITNESSED BELOW:

THE UNDERSIGNED HEREBY SWEARS UNDER PENALTY OF PERJURY THAT ALL OF THE INFORMATION PROVIDED HEREIN IS TRUE AND ACCURATE.

CLAIMANT'S NAME: _____
[PRINT NAME]

X_____**[SIGN HERE]**
SIGNATURE OF CLAIMANT

WITNESS TO CLAIMANT SIGNATURE NAME:_____

X_____**[SIGN HERE]**
SIGNATURE OF WITNESS

(Detach and complete if you have a new address)

CHANGE OF ADDRESS INFORMATION

(Please Print)

Name: .....

Old Address: .....

City and State: ..... Zip Code: .....

New Address (Street or P.O. Box): .....

City and State: ..... Zip Code: .....

Please mail to:

The Pensacola CBDF Explosion Settlement
Ed Gentle
Settlement Administrator
501 Riverchase Parkway East, Suite 100
Hoover, Alabama 35244
pensacolasettlement@gtandslaw.com
205-716-3000
855-711-2079

SCHEDULE OF ATTACHMENTS

Attachment 1:	**The Legal Basis for the Inmate Account Compromise**
Attachment 2:	**Estimated Distribution of the Proposed $17,500,000 Gross Settlement Amount**
Attachment 3:	**Description of the Grave Injuries of Each of the Three Gravely Injured Claimants**
Attachment 4:	**W-9**
Attachment 5:	**Lien Form I of II - Government Benefits Questionnaire**
Attachment 6:	**Lien Form II of II**
Attachment 7:	**Declaration of Assent, Release and Indemnity Agreement by Participating Settlement Class Member(s)**
Attachment 8:	**Summary of Matrix Computations**
Attachment 9:	**Claimant Scoring Agreement**

ATTACHMENT 1 TO CLAIM FORM:

THE LEGAL BASIS FOR THE INMATE ACCOUNT COMPROMISE

Escambia County, Florida, which owned the prison where the Fire occurred, is paying $5Million of the Settlement amount.

Unlike non-Inmates, who were County Employees or First Responders working for the County or other Governmental agencies, many of whom have a workers compensation claim, the Inmates cannot sue the County under state law based on an immunity defense. However, Inmates can sue the County under Federal Civil Rights laws, including the Fourth and Eighth Amendments to the U.S. Constitution and Section 1983.

Counsel for the Inmates argue that the $5 Million from the County is in Settlement of these Inmate Civil Rights claims. On the other hand, Employees have Workers' Compensation Claims totaling up to $4 Million, and their lawyers believe that these Claimants should be given priority because of these Claims.

To compromise these competing Claims, a separate Inmate Account in the amount of $2,520,000 has been established. Only Inmates will be paid from this account. The other account contains $14,980,000, and will be used to pay all Claimants, including Inmates and Employees.

ATTACHMENT 2 TO CLAM FORM:

ESTIMATED DISTRIBUTION OF THE PROPOSED $17.5 MILLION SETTLEMENT AMOUNT*

*This insurance coverage includes defense costs. If this case doesn't settle, the amount available to pay claims will drop. $17,500,000 is the MAXIMUM amount of the Settlement, as some of the insurance policies are eroding due to the payment of legal fees. The actual amount is $17,642,000,and was announced by the Defendants at the Preliminary Approval Hearing, and may continue to erode due to additional payment of legal fees. Therefore, the $17,500,000 amount is a good estimate of what will be available at the time of your payment.

Attachment 2

ESTIMATED DISTRIBUTION OF
THE PROPOSED $17,500,000 GROSS SETTLEMENT AMOUNT

A.	**Legal Fees and Expenses**		
	1.	Gross Settlement	$17,500,000
	2.	Legal Fees and Expenses Account for the Law Firms of the Represented Class other than the 3 Gravely Injured Claimants, equal to 1/3 of the $9,000,000 gross amount available to pay the Non-Gravely Injured Claimants (defined below)[1]	($3,000,000)
	3.	Legal fees and expenses for lawyer advising the 222 pro se Claimants[2]	($100,000)
	4.	Amount for Personal Injury Payment Program	$14,400,000
B.	**Personal Injury Payment Program**		
	1.	Amount for Personal Injury Payment Program	$14,400,000
	2.	Claims Administrator Fees and Expenses for 668 Claimants ($400 per Claimant paid ratably by all Claimants)[3]	($267,200)
	3.	$250 Advance Payment Checks for all 668 Plaintiffs	($167,000)
	4.	Amount Paid to the Three Gravely Injured Claimants After Their Share of Items B2 and B3	($8,369,661)
	5.	Amount for Proposed Matrix for Claimants Other Than Gravely Injured Claimants[4]	$5,596,139.00

[1] Represented Claimants had a written representation agreement with a Law Firm by December 15, 2015. This legal fees and expense account amount equals 1/3 of the $9,000,000 recovery for all Claimants other than the 3 Gravely Injured Claimants, whose legal fees come out of their individual recovery. Most law firms have a written agreement with a Represented Claimant providing for a legal fee of 1/3 of the Claimant's recovery plus legal expenses. It should be noted that there are 222 pro se Claimants who are not represented, and who will not owe legal fees. Therefore, this reserve amount should be more than adequate, so that the non-Gravely Injured Claimants may receive a ratable dividend, subject to the All Claimants Account/Inmate Account distributions split described in Footnote***** to the Potential Settlement Explanation and Scoring Form, after all legal fees and expenses are paid. Legal fees and expenses will only be paid for Claimants represented by a Law Firm at December 15, 2015 . This will be done with a "gross up computation". For example, if a Claimant represented by a law firm has a total recovery after fees and expenses of $5,000, and the law firm representing the Claimant is entitled to $200 for out-of-pocket legal expenses, and a 1/3 legal fee, the law firm will receive from this account, $2,463 in legal fees and $200 for legal expenses.

[2] Any of this amount that remains after the payment of all legal fees and expenses for the lawyer advising the 221 pro se Claimants will be paid ratably to all Claimants other than the 3 Gravely Injured Claimants and those in the First Responder Category , subject to the All Claimants Account/Inmate Account distributions split described in Footnote***** to the Potential Settlement Explanation and Scoring Form.

[3] This $400 per Claimant charge is being paid ratably by all Claimants. It includes the processing of Governmental liens, like Medicaid and Medicare. If you have private liens to resolve, there will be an additional $250 charged only to your recovery and not ratably to all Claimants that is not reflected here. There will also be a $250 additional charged only to your recovery and not ratably to all Claimants that is not reflected here to process a DHR or restitution lien, or any other lien or judgment.

[4] Of this amount, (i) $4,790,851.38 (the "All Claimants Account") is to pay all Claimants ratably, and (ii) $805,287.62 is to pay Inmate Claimants only (the "Inmate Account"), or 85.6% and 14.4%, respectively, of the total amount of $5,596,139 available to pay the claims of Non-Gravely Injured Claimants under line 6 of Attachment 1.

ATTACHMENT 3 TO CLAIM FORM:

DESCRIPTION OF THE GRAVE INJURIES OF EACH OF THE THREE GRAVELY INJURED CLAIMANTS

PARAPLEGIC EMPLOYEE CLAIMANT

Claimant is 44 years old and is married with three minor children. On the night of the explosion, the Claimant was in the property room on the ground floor. When the explosion occurred, he shot up into the ceiling above him and then fell through the floor into a pit of debris filled water. He felt immediate excruciating pain in the top half of his body but felt nothing below the waist. He struggled to keep his head above water. A fellow guard held his head while balancing on a large piece of debris for over an hour while the rescue squad looked for them. After being rushed to Baptist hospital, the Claimant was diagnosed with a thoracic spine fracture with paralysis, traumatic aortic transection and closed scapula fracture. The aortic repair was done first and once stabilized he was sent via life flight to UAB where he underwent numerous surgeries including a spine stabilization. During one of the surgeries his spleen and diaphragm were punctured resulting in a hemorrhage that almost killed him. His heart stopped beating at one point, he developed MRSA and pleural effusion. He was eventually discharged from UAB three weeks later and transferred to NeuLife Rehab in Mt. Dora Florida. The Claimant lived at NeuLife for 4 months where they taught him how to live life as a paraplegic.

A very conservative life care plan was done and projected costs of $2,339,480. The economic loss report was calculated and determined economic losses alone to be $4,224,934. Average pain and suffering awards for paraplegics in Florida run around $10,000,000.

DECEASED INMATE CLAIMANT WITH 5 SURVIVORS

According to the autopsy report, the Claimant died due to multiple injuries. The deceased Claimant left five children. Prior to his incarceration, the Claimant was a highly successful businessman who had developed an addiction to prescription pain medicine. His child support payments were $3,147.22 per month based on a net monthly income of $10,415.67. At the time of his death, he was free of the drug and was working on a 12 step program and faith to return tho the life he had prior to the pain killer addiction. Claimant was found dead at the jail as a result of the explosion that occurred.

Claimant is survived by two sons and three daughters. One son is 25 and actively employed in the family business. One son is 17, has Cystic Fibrosis and studies computer engineering at USF. His oldest daughter attends Florida State University, and two he has two younger daughters who are 16 and 13 respectively. They all miss their father very much.

DECEASED INMATE CLAIMANT WITH 1 SURVIVOR

According to the autopsy report, the Claimant died due to multiple injuries.

Claimant worked independently as a mechanic, until health problems rendered him disabled preceding his death. In an effort to deal with the pain of his disability, Claimant occasionally resorted to drugs to help him cope, and, unfortunately, he was awaiting a revocation hearing for violating his probation when the jail exploded. Claimant died as a result of the explosion.

Claimant's only child learned of the Escambia County Jail explosion the morning of May 1, and made over 30 calls to the hotline set up for the family members of inmates, but was unable to get a status regarding her father. She found out what happened to her father when the Coroner came to her house more than 24 hours after the explosion with a picture of her father.

Claimant was only 54 at the time of his death, and his daughter was 26. Claimants daughter was very close to the Claimant, who supported her both financially and emotionally.

ATTACHMENT 4 TO CLAIM FORM:

W-9

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

ATTACHMENT 5 TO CLAIM FORM:

LIEN FORM I OF II GOVERNMENT BENEFITS QUESTIONNAIRE

GENTLE, TURNER, SEXTON & HARBISON, LLC
Lien Resolution and Settlement Administrator
501 Riverchase Parkway East, Suite 100
Hoover, AL 35244
(p) (800) 345 0837
(f) (205) 716-2364

PLEASE READ FIRST

Instructions for Completing Lien Resolution Documents:

Our firm will be resolving medical liens for your personal injury case. This includes, but is not limited to:

- Medicare – Federal health insurance for those aged 65 and older or on disability for more than 24 months
- Medicaid – State administered, income based health insurance
- Military health insurance or Veteran's Administration health benefits
- Any other government agency which may notify this firm or your plaintiffs' attorney's firm of a lien (i.e., unemployment health insurance, medical services while incarcerated, Indian Health Services, County DA offices, County DHR offices)
- Private health insurance (Blue Cross Blue Shield, United Healthcare, Humana, etc.)
- Medical care providers (hospitals, doctors, etc.) – in the event you did not have health insurance, a hospital or doctor may be entitled to recover medical expenses

In order to resolve liens as quickly and efficiently as possible, we have 4 documents that must be completed in order to expedite the resolution of any liens. They are described below along with some instructions for completing the forms. Failure to correctly complete any of the forms will result in a lengthier lien resolution process.

I. **"Government & Private Benefits Questionnaire"** – This form is used to obtain general and necessary information about you in order for us to be able to resolve liens on your behalf and/or perform settlement administration duties with the ultimate goal being to get you paid. Please fill out all pages of this form with information about the **Claimant**. If the Claimant is deceased and you are the representative for the Claimant, fill the form out for the **Claimant**, not for yourself, and attach appropriate appointment documents (Letters of Administration, Letters Testamentary, POA, GAL, etc.). Make sure you list your COMPLETE address including city, state and zip code along with your current telephone number so that we may contact you if we need further information. The full social security number

is required in order for us to adequately verify and resolve your liens should there be any. Complete all sections on all 5 pages as thoroughly as possible. Make sure you remember to sign and date the form on the last page. You will be signing this document under penalty of perjury, so please make sure all information provided is accurate. **Please feel free to call our office at 1-800-345-0837 if you need any assistance or have any questions about this document. Deficient documents will be set aside and processed last, after all complete documents are processed. We will have to contact you or your attorney to correct any deficiencies.**

II. **"Proof of Representation"** – This form will be used for communication with **Medicare** only. With respect to Medicare, YOU are the beneficiary. Any references to the "beneficiary" on this form are references to you. You are the only person who should sign in the beneficiary designated area. If you believe that you don't have Medicare, just sign and date the form in the Medicare beneficiary section. Do not write NA in the blanks. If you know that you are a Medicare beneficiary, please complete the Medicare beneficiary section only. If you don't know an answer, please leave the question blank. Do not have anyone sign in the Representative area. This is where our attorney will sign so that we may obtain information from Medicare. Also, please attach a copy of your Medicare card, if you have one. **Please feel free to call our office at 1-800-345-0837 if you need any assistance or have any questions about this document. Deficient documents will be set aside and processed last, after all complete documents are processed. We will have to contact you or your attorney to correct any deficiencies.**

III. **"Authorization to Disclose Health Information"** – This form will be used for **Tricare, Veteran's Administration, private insurance agencies and/or any other type of medical insurance you may have**. Fill in your name, SSN and DOB at the top and sign at the bottom. On number 1, If you do not know the official name of your Medicaid, Tricare, Veteran's Administration and/or private or other insurance agency(ies), please leave this area blank and we will fill it in for you. On number 2, your dates of service should start with your official injury date or date of first ingestion or exposure and extend through the settlement date of your case. If you do not know your exact injury/first ingestion/first exposure date, please leave this area blank and we will fill it in for you. If you have more than one health insurance provider, please complete one of these documents for each of the applicable agencies listed above. Please be advised that if you fail to sign multiple copies, we will make photocopies of your signed form, if needed. Do not write NA in the blanks. **Please feel free to call our office at 1-800-345-0837 if you need any**

assistance or have any questions about this document. Deficient documents will be set aside and processed last, after all complete documents are processed. We will have to contact you or your attorney to correct any deficiencies.

IV. **"Medicaid Third Party Liability – Authorization for the Use and Disclosure of Protected Health Information"** – This form will be used to obtain benefit information from **Florida** Medicaid. It is very similar to the form described in III above, but it is used only for Florida Medicaid and it is required by Florida Medicaid. Even if you believe that you do NOT have Florida Medicaid, please sign and date the form at the bottom. If we find out later that you did have Florida Medicaid and we do not have the signed form on file, your claim will be delayed. **Please feel free to call our office at 1-800-345-0837 if you need any assistance or have any questions about this document. Deficient documents will be set aside and processed last, after all complete documents are processed. We will have to contact you or your attorney to correct any deficiencies.**

Tips for form completion:

1. Answer all questions, including yes or no questions. **If you don't have a particular benefit/service about which we are asking, don't leave the question blank. Answer NO**. If you answer "yes" to any questions, make sure to complete any additional questions in that section, as instructed on the form.
2. We do need your full Social Security Number. We cannot process liens or payments without it. We do not share this information with anyone other than the health insurance providers or other lienholders mentioned in this document and/or the Internal Revenue Service. Any discarded documents containing personal information are placed in a secure, locked bin for shredding.
3. If you are a U.S. Veteran, be sure to list all facilities from which you received medical treatment from the Department of Veterans Affairs along with the city and state, as requested on the Benefits Questionnaire, **even if you did NOT visit the VA for case-related medical care**. Providing this information will enable the Department of Veterans Affairs to more quickly access your information.
4. If you don't have Medicare or any other insurance, please do not write NA all over the forms. Please fill in your name, sign and date the forms where indicated. If we need them later, we won't have to contact you for them, thus reducing the lien resolution processing time.
5. Please complete all forms, even those which you believe don't apply to you. Having all forms on hand will save time.

6. Make sure to call our office or your Plaintiffs' Attorney's office if you have a change or addition to any of the information you provided on the forms, including your address.
7. FILL OUT ALL SECTIONS OF ALL DOCUMENTS COMPLETELY AND LEGIBLY.
8. Check your packet before sealing the envelope to make sure that all pages and forms are included, including copies of any insurance cards.
9. Please call us at 1-800-345-0837 if you have any questions or need assistance filling out any of these documents. We are happy to help!
10. **Deficient document packets will be set aside and processed last, after all complete packets are processed. We will contact you or your attorney to correct any deficiencies.**

We understand that you are anxious to receive your Settlement funds, if you are due Settlement funds, and put an end to the long process of being a part of the Settlement. Please keep in mind that the lien resolution process must be complete before we can authorize your payment. Even if you are no longer a beneficiary of a government medical insurance agency, we must have confirmation of your status from the agency. Each insurance agency has its own process to follow in order to report liens back to us, and these processes cannot be modified. They can be time consuming and there is nothing that can be done to lessen the time it takes to resolve liens. We are happy to provide periodic status updates or to answer any questions you may have about your case or your lien resolution process. However, frequent and multiple calls to check status will only delay the payment and lien resolution process. If you need to call us, our number is 1-800-345-0837.

We want to get you paid! That's part of our job. We will process your payment authorization once all liens are resolved.

GOVERNMENT AND PRIVATE BENEFITS QUESTIONNAIRE

GENTLE, TURNER, SEXTON & HARBISON, LLC
501 RIVERCHASE PARKWAY EAST, SUITE 100
HOOVER, ALABAMA 35244
TOLL FREE (800) 345-0837 • LOCAL (205) 716-3000 • FAX (205) 716-2364
OUR FILE NO. 6338-1

I. BASIC INFORMATION

– If you are completing this form on behalf of a Claimant (as Parent, Guardian, Representative, POA, GAL, etc.), **complete this entire form using information for the Claimant and attach a copy of the documentation designating you as such. PLEASE WRITE LEGIBLY.**

Name: _____ Date of Birth: ____/____/____
(First) (M.I.) (Last) mm/dd/year

Current Address: _____

City: _____ State: _____ Zip: _____

Full SSN: _____ Telephone: (_____) _____ Mobile: (_____) _____
(Required)

Email Address: _____

Marital Status: Single/Never Been Married ☐ Married ☐ Name of Spouse: _____
Divorced ☐ Date Divorced _____

Is the Claimant deceased? YES ☐ NO ☐ If yes, state your relationship to Claimant: _____
(Attach Representative Documentation)

II. INJURY INFORMATION

Date of your injury, ingestion, exposure or accident: _____

City, State and County in which your injury occurred: _____

If your injury is due to an ingestion or exposure, date of **FIRST** ingestion or exposure: _____

Briefly describe your injuries related to this case as diagnosed by a doctor: _____

_____

_____

III. GOVERNMENT BENEFIT INFORMATION

A. Are you eligible for ***MEDICARE*** Parts A &/or B benefits? **YES ☐ NO ☐**
(If you are 65 or older, you are automatically eligible)

i. On what date did the benefits begin? _____

ii. Please list your Medicare number (HICN): _____

*******PLEASE ATTACH A COPY OF YOUR MEDICARE CARD*******

GOVERNMENT BENEFIT INFORMATION, CONT.

B. At the time of your injury, were you receiving ***MEDICAID (state sponsored, needs-based)*** benefits? **YES** ☐ **NO** ☐
(this includes Managed Care Organizations that fall under Medicaid)

i. On what date did the benefits begin? _____

ii. From which state do you receive your Medicaid benefits? _____

iii. Please list your Medicaid number: _____

iv. If known, list your Medicaid Managed Care Organization: _____

*******PLEASE ATTACH A COPY OF YOUR MEDICAID CARD*******

C. Since your injury, have you begun to receive ***MEDICAID (state sponsored, needs-based)*** benefits? **YES** ☐ **NO** ☐
(this includes Managed Care Organizations that fall under Medicaid)

v. On what date did the benefits begin? _____

vi. From which state do you receive your Medicaid benefits? _____

vii. Please list your Medicaid number: _____

viii. If known, list your Medicaid Managed Care Organization: _____

*******PLEASE ATTACH A COPY OF YOUR MEDICAID CARD*******

D. Have you ever received ***MEDICAID*** benefits in another State? **YES** ☐ **NO** ☐
(if you had Medicaid in more than 1 other state, please list them on a separate sheet and attach)

i. On what date did the benefits begin? _____

ii. From which state did you receive your Medicaid benefits? _____

iii. Please list your Medicaid number: _____

iv. If known, list your Medicaid Managed Care Organization(s): _____

*******PLEASE ATTACH A COPY OF YOUR MEDICAID CARD*******

E. Have your ever received ***Military medical insurance (Tricare)***? **YES** ☐ **NO** ☐

If YES, are you the Sponsor or a Dependent? (circle one) **SPONSOR** **DEPENDENT**

If YES, in what branch of the Armed Forces did you or the sponsor serve? _____

Please list approximate dates of your Tricare Coverage: _____

Sponsor Name and ID number: _____

Health program plan name (Prime, For Life, etc.): _____

City, county and state in which your injury occurred: _____

GOVERNMENT BENEFIT INFORMATION, CONT.

F. Are you eligible to receive **ANY** medical treatment at a ***VA hospital or other VA facility***? **YES** ☐ **NO** ☐

If YES, please list the names and locations (city and state) of all VA treatment facilities from which you have received ANY medical treatment, even if the medical treatment is not related to this case (attach additional pages, if needed):

_____

_____

_____

_____

_____

G. Have you ever received Government ***Disability*** or ***SSI*** payments? **YES** ☐ **NO** ☐

i. Below, indicate which type of disability benefit you receive(d):

_____ **SSI** - Supplemental Security Income (needs-based)

On what date did your benefits begin? _____

_____ **SSDI** - Social Security Disability Insurance

On what date did your benefits begin? _____

IV. PRIVATE BENEFIT INFORMATION

A. Did you have private health insurance at the time of your personal injury? **YES** ☐ **NO** ☐
(this includes plans for Medicare Parts C &/or D and ANY Medicare supplement plan)

If so, complete the following: (if you had more than 1 other insurance company, please list them on a separate sheet and attach)

Full name of your private insurance company: _____

Member ID #: _____

Group #: _____ Policy #: _____

Insurance Company's phone #: (may be found on the back of your insurance card): _____

Insurance Company's Address: _____
Street

_____
City State Zip

*******PLEASE ATTACH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD(S)*******

PRIVATE BENEFIT INFORMATION, CONT.

B. Do you currently have different private health insurance than the one listed above? **YES** ☐ **NO** ☐
(this includes plans for Medicare Parts C &/or D ANY Medicare supplement plan)

If so, complete the following: (if you had more than 1 other insurance company, please list them on a separate sheet and attach)

Full name of your private insurance company: _____

Member ID #: _____

Group #: _____ Policy #: _____

Insurance Company's phone #: (may be found on the back of your insurance card): _____

Insurance Company's Address: _____
Street

_____
City State Zip

*****PLEASE ATTACH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD(S)*****

V. OTHER GOVERNMENT DEBTS

A. Have you ever declared Bankruptcy? **YES** ☐ **NO** ☐

If Yes, provide: Filing date(s): _____ Discharge date(s): _____

Please circle bankruptcy type: CHAPTER 7 CHAPTER 11 CHAPTER 13

State(s) in which case(s) was filed: _____

Is your bankruptcy case still active? **YES** ☐ **NO** ☐

B. Do you owe restitution to the District Attorney's office? **YES** ☐ **NO** ☐

If Yes, which County? _____

Case Number, if known: _____

Name & phone number of contact: _____

C. Do you owe child support or another debt to the Department of Human Resources? **YES** ☐ **NO** ☐

If Yes, which County? _____

Case Number, if known: _____

Name(s) of dependents: _____

_____

Name & phone number of contact: _____

VI. RELEASE AND SIGNATURE

By signing below, you agree to the release of the information given, and your name, address, Social Security number, and date of birth to the Private and/or Governmental Agencies referenced in Parts III and IV above. It is your responsibility to notify us if any of your benefit information changes or needs to be supplemented. **The undersigned hereby swears under penalty of perjury that all of the information provided herein is true and accurate.** Your signature if an adult; Parent or Guardian's Signature if a Minor; or Personal Representative's Signature if Claimant is incapacitated or deceased:

_____ Date: _____/_____/_____

Claimant's Signature
(or Representative's Signature)

If you are signing as a Representative, please state your relationship to the Claimant:_____

****If you have signed this document as a Representative, you must attach documents designating you as such.****

PLEASE MAKE SURE THAT YOU COMPLETE & RETURN ALL PAGES OF THIS FORM. MISSING OR ILLEGIBLE INFORMATION AND/OR PAGES WILL DELAY THE PROCESSING OF YOUR CLAIM.

ATTACHMENT 6 TO CLAIM FORM:

LIEN FORM II OF II

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name: _____

Date of Birth: _____ SSN: _____

1. The following individual or organization is authorized to make the disclosure (if you are unsure of entity's legal name, please leave blank):

   _____

2. The type and amount of information to be used or disclosed as follows:

   The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies (if unsure of exact dates, leave blank).

   Dates of Services: From: _____ To: _____

3. I understand that the information in my health records 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.

4. This information may be disclosed to and used by the following individual or organization:

   GENTLE, TURNER, SEXTON & HARBISON, LLC
   501 Riverchase Parkway East, Suite 100
   Hoover, Alabama 35244
   (p) 205-716-3000 (f) 205-716-2364

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire upon the settlement of my claim.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollment in my Health Plan, or my eligibility for benefits upon my giving this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM director, privacy officer, or other release of information employee of the above named healthcare provider.

_____ _____ _____

Patient or Legal Representative Date Relationship to Patient (If signed by Legal Representative)

MEDICARE PROOF OF REPRESENTATION

Sign below if you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. Your representative must also sign that he/she has agreed to represent you.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
(X) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: Edgar C. Gentle, III, Esq. and Katherine A. Harbison, Esq.
Relationship to Medicare Beneficiary: Lien/Settlement Administrator
Firm or Company Name: Gentle, Turner, Sexton & Harbison, LLC
Address: 501 Riverchase Parkway East, Suite 100
Hoover, AL 35244
Telephone: (p) 205-716-3000 (f) 205-716-2364

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

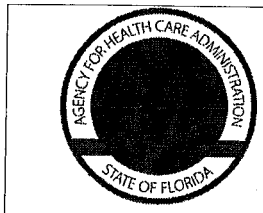
Beneficiary Signature: _____ Date signed: _____

For Lien Administrator's Use Only – Do Not Write or Sign Below this Line:

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

Our File No.: _____



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

Authorization for the Use and Disclosure of Protected Health Information

Federal law states that we cannot share an individual's health information without the individual's permission, except in certain situations. By signing this form, you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share this information any more, you can revoke this authorization at any time in writing or sign the REVOCATION SECTION on the back of this form and return it to the Florida Medicaid TPL Recovery Program. This form must be completed and signed by the Medicaid recipient or by an individual who has the authority to act on the Medicaid recipient's behalf (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

PLEASE COMPLETE THE FOLLOWING SECTIONS

1. Personal Information:

Medicaid Recipient's Name_____

Date of Birth_____

Medicaid ID Number_____ Social Security Number_____

2. I give permission to the Agency for Health Care Administration (AHCA) and its contract representatives to share the health information listed below with the following:

Name of the Law Firm or Law Office_____

Name of the Insurance Company_____

Other_____

3. Indicate the purpose for which the disclosure is to be made:

____To substantiate Medicaid's lien relating to a lawsuit
____To substantiate Medicaid's claim against the estate or against a trust account or annuity
____Other _____

4. Indicate the information that you want to be disclosed, related to the following (check one):

____The Medicaid lien *relating to the injury or negligence* charges, for the period beginning with the date of incident.
____Medicaid's claim against the *estate.*
____The amount that is due Medicaid from the *trust account, [Please send a copy of the trust agreement].*
____The amount that is due Medicaid from the *annuity account, [Please send a copy of the annuity agreement].*
____Other*[Pleasebespecific].*_____

5. Enter the specific date that you want this authorization to expire: (i.e., 1 year from date of release)_____
(If you do not enter a date, this authorization will expire in five years.)

I understand that the information described above may be redisclosed by the person or group that I hereby give AHCA and its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release AHCA, its workforce members, and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement. I understand that I may inspect or request copies of any information disclosed by this authorization if AHCA or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying AHCA through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.

Recipient Signature _____ **Print Name**_____ **Date**_____

OR

Name of Legal Representative (Print)_____ **Relationship**_____

Signature of Legal Representative * _____ **Date**_____

* If you are not the individual, but represent the individual, please attach a copy of the legal document that verifies that you are a representative (parent of a minor, legal guardian, trustee, power of attorney, personal representative of the estate, grantor of an annuity).

INSTRUCTIONS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Complete the front of the form and return it to Florida Medicaid TPL Recovery Program, Post Office Box 12188, Tallahassee, Florida 32317-2188, Phone (toll-free) (877) 357-3268 or Fax (844) 845-8352.

2. If the signer is a guardian, has a power of attorney or is an authorized representative, documentation of the representative's authority to act on the individual's behalf must be attached. If an agency has custody of a child and a representative signs the release, include a copy of the custody order.

3. Special kinds of health information have specific laws and rules that have to be followed before that information can be disclosed.

HIV and Sexually Transmitted Diseases (STD): All information about HIV and sexually transmitted diseases is protected under federal and state laws and cannot be disclosed without your written authorization unless otherwise provided in the regulations. To release HIV or STD information, this authorization must include a statement in the Information You Want Disclosed section of the specific HIV or STD information that you are giving permission to release. Re-disclosure of HIV information is not allowed, except in compliance with law or with your written permission.

Alcohol and Drug Treatment: Alcohol and/or drug treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise provided for in federal and state laws or regulations. To release alcohol and drug treatment information, this authorization must include a statement in the Information You Want Disclosed section of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." Re-disclosure of you alcohol and/or drug treatment records is not allowed, except in compliance with law or with your written permission.

Mental Health Treatment: Mental health treatment records are protected under federal and state laws and regulations and cannot be disclosed without your written authorization, unless otherwise allowed in federal and state laws or regulations. To release mental health treatment information, this authorization must include a statement in the Information You Want Disclosed section of the specific information that you are giving permission to release, such as "assessment, treatment plan, attendance, discharge plan." Also, disclosure of your therapist's own notes (psychotherapy notes) needs separate permission. Re-disclosure of your mental health treatment records is prohibited, except in compliance with law or with your written permission.

4. You will be provided with a copy of this form.

REVOCATION SECTION

To revoke your authorization, complete the following section and return the form to the Florida Medicaid TPL Recovery Program at the address given above. (Use of this form to revoke your authorization is optional; however, you must submit your revocation request in writing.)

I no longer want my information shared.

Name_____

Date of Birth_____

Street Address_____

City_____ State _____ Zip_____

If applicable, your Medicaid ID number_____

Signature_____Date_____
OR
Signature of Authorized Representative_____Date_____

Relationship of Authorized Representative_____

ATTACHMENT 7 TO CLAIM FORM:

DECLARATION OF ASSENT, RELEASE AND INDEMNITY AGREEMENT BY PARTICIPATING SETTLEMENT CLASS MEMBER(S)

DECLARATION OF ASSENT, RELEASE AND INDEMNITY AGREEMENT BY PARTICIPATING SETTLEMENT CLASS MEMBER(S) ["RELEASE"]

Name(s) of Plaintiff(s) in Lawsuit: _____

Docket Number of Lawsuit: _____

If Applicable, Name and Capacity of Bankruptcy Trustee, Personal Representative, Guardian, Conservator, or Other Successor Real Party in Interest for any Plaintiff:

_____

_____

_____

Declaration of Assent: I declare under penalty of perjury and warrant that all information in this Declaration of Assent, Release and Indemnity Agreement accurately states all information and does not fail to include any fact necessary to prevent the information provided from being misleading or incomplete.

By signing this document I represent, warrant and agree that:

a. I have read and fully understand all provisions of the Settlement Agreement and Release ("the Agreement")[1] by and between A.E. New, Jr., Inc., BITCO (as defined in the Agreement), Alliance Laundry Holdings, LLC, Sentry Insurance Co., The City of Pensacola d/b/a Pensacola Energy, Caldwell Associates Architects, Inc., Atlantic Specialty Insurance Co., Coin Laundry Equipment Co., Inc., Certain Underwriters at Lloyd's, London, Escambia County (as defined in the Agreement), Columbia Casualty, Co., Great American Excess & Surplus Co., Futch Design Associates, Inc., AXIS Surplus Insurance Co., Glaze Communications, Westfield Insurance Co., H.M. Yonge & Associates, Inc., Liberty International Underwriters, Klocke and Associates, Inc., XL Specialty Insurance Co., Premier Engineering Group, LLC, AXIS Insurance co., Rebol-Battle & Associates, Landmark American Insurance Company, which shall include RSUI Group,

[1] I understand that capitalized words and phrases in this document have the same meaning as in the Agreement.

Inc., SEMCO of Pensacola Inc., and Southern-Owners Insurance Co., and Associated Electric and Gas Services, Ltd. and Executing Counsel (the "Agreement").

b. I have had the benefit of all the legal advice I need, or want, to understand the meaning and effect of every part of the Agreement, including this Declaration of Assent and Release that I am signing and the effect of the Indemnity Agreement it contains.

c. I am aware that if I do not have an attorney of my own, Robert Heath, Esq., has been appointed by the Court hearing the Action to provide me with assistance and to answer my questions.

d. I assent to become a Party to the Agreement together with Executing Counsel and every other Participating Claimant, and I assent to all provisions of the Agreement. I understand that this assent includes all of the definitions, conditions, warranties, covenants, releases, indemnities and other provisions of the Agreement, whether they are repeated in this Declaration of Assent and Release or not.

1.1 **Complete Release.** For the consideration described in the Agreement, the receipt and sufficiency of which is acknowledged, and subject to the conditions in this Release, I hereby remise, release, discharge and forever acquit each and every one of the Defendants and Insurers (as defined in the Agreement) and all other Released Persons, jointly and severally, and each and all of their respective parent, subsidiaries, affiliates, managers, members, owners, partners, shareholders, agents, servants, employees, officers, elected and/or appointed officials, independent contractors, representatives, successors, assigns, attorneys, and any and all other persons, firms and/or entities who may in any manner be liable for any Released Claim or Released Claims, and each of

them, jointly and severally and in all capacities, from any Claim or Claims that I may now or may hereafter have, on account of or in any way relating to or arising out of the Explosion.

1.2 **Acknowledgement of Future Released Claims.** In connection with the complete release in Section 1.1 and to the fullest extent allowed by law, I acknowledge that I may hereafter discover claims presently unknown or unsuspected, or facts in addition to or different from those which I now know or believe to be true with respect to the Released Claims. Nevertheless, it is my intention to fully, finally and forever settle and release all such Released Claims, and all Claims and claims relating thereto, that exist, hereafter may exist, or might have existed (whether or not previously or currently asserted in any action) and accrued on or before the date that the Final Judgment and Order of Dismissal is entered as to all Released Persons. In this regard, I expressly waive, to the fullest extent allowed by law, any potentially applicable statutory, regulatory or common law provisions that arguably provide otherwise. As a part of this release, I agree never to file any Claim in any administrative agency against any Released Person arising out of, connected with, or in any way relating to the Explosion.

1.3 **Exclusive Remedy**. Timely submission of a Claim Form in accordance with the procedures set forth in this Agreement is the **EXCLUSIVE** method and remedy of all Settlement Class Members for any and all Released Claims. A Claim Form timely submitted hereunder shall be in lieu of any other remedy or right of action against the Defendants and Insurers for the Released Claims. Accordingly, no Defendant or Insurer

or Released Person shall be subject to liability or expense of any kind to any Settlement Class Member with respect to any Released Claims, other than as set forth in this Agreement. I understand that if I fail to timely submit a Claim Form that fully complies with all requirements or fail to execute documents as directed by the Court of Claims administrator, this Release will be fully effective as to my Claims as set forth herein as though I had executed this Release.

1.4 **Covenant Not To Sue.** I will not commence, prosecute, or cause to be commenced or prosecuted against, or with regard to the asserted conduct of any Defendant or Insurer or Released Persons any action or other proceedings based upon any Claim or Released Claims.

1.5 **Injunction Against Additional Litigation**. Upon Final Approval, I acknowledge and agree that I shall immediately be enjoined from filing or becoming part of any action, including, without limitation, any putative class actions, filed against the Defendants or Insurers or Released Persons or any other person or entity, insofar as those actions relate to any of the Claims or Released Claims or otherwise interfere with this Agreement or the Settlement of the class action claims generally.

1.6 **Settlement Class Members' Agreement to Indemnify and Hold Harmless Respecting His or Her Liens and Subrogation Claims**. *I agree that I am responsible for satisfying all of my respective Liens, subrogation interests including, but not limited to, Liens or subrogation claims brought by Florida Department of Revenue, Florida Health Care Administration, Medicaid,*

Medicare, the Florida League of Cities, or any other private health or property insurance companies, and private causes of action provided in the Medicare Secondary Payer (MSP) Act, 42, U.S.C. Section 1395y (b)(3)(A), should Medicare deny coverage for any reason, including the failure to allocate adequate money to future Medicare covered medical expenses in this settlement or to otherwise protect Medicare's interests, medical expenses, workers' compensation benefits, restitution obligations and all other similar or related expenses pertaining to, arising out of or in connection with the Claims and/or Released Claims. I will indemnify and hold harmless the Defendants and Insurers and Released Parties against any and all such claims, suits, complaints or causes of action brought against any of the Released Parties and pertaining to, arising out of or in connection with the Claims and Released Claims including claims based upon Liens or any other suit or demand as set forth in this paragraph. I will be responsible for the Defendants', Insurers' and Released Parties' costs of defending against these claims, suits, complaints and causes of action, including any legal fees and court costs and agree to indemnify and hold harmless the Defendants and Insurers and Released Parties for all such fees and expenses as set forth in this Section. I will be responsible for paying any judgment against or settlement reached by the Defendants and/or Insurers and/or Released Parties in such claims, suits, complaints and causes of action. The Defendants and Insurers and Released Parties are not responsible for the expenses, costs or liabilities described in this Section, and Defendants' and Insurers' and Released Parties' monetary obligations under this Agreement are expressly limited to the settlement amounts set forth in Section 1.30 of the Settlement Agreement.

I have read and understand my obligations under this Indemnity Agreement.

Initials of all persons executing this Indemnity Agreement: _____

1.7 **Continuing Rights.** Nothing contained herein releases, nor shall be construed to release, any continuing rights that I may have resulting from the Agreement and the remedies and benefits created and conferred hereby.

1.8 **Assent to Confidentiality.** I understand that the covenants in this Release and the Settlement Agreement regarding confidentiality and prohibition of public comment are equally significant provisions of the Settlement Agreement, just like all others. I agree not to disclose or comment upon the existence or provisions of the Settlement Agreement, or actions taken pursuant to it, except as specifically permitted in the Settlement Agreement. If I am unclear about this obligation in a particular situation, I will consult with Executing Counsel, Robert Heath or the Settlement Admnistrator before taking any action.

1.9 **Assent Includes Entire Agreement.** I understand and acknowledge that this Declaration of Assent and Release does not repeat all the provisions of the Agreement, and uses terms defined in the Agreement to have specific meanings which are not all repeated in this Declaration. I understand and acknowledge that what I am agreeing to, by signing this Declaration, is to be bound by all the contents of this Declaration, and thereby to be bound by all of the provisions of the Agreement, whether those provisions are repeated in this Declaration or not. I have read and understood the entire Agreement, and assent to all of its provisions as written.

Signature(s) of Plaintiff(s) if Current Real Party(ies) in Interest:

_____ _____

[Signature] [Date]

_____

[Printed Name]

_____ _____

[Witness Signature] [Date]

_____

[Witness Name]

Signature(s) of Bankruptcy Trustee, Personal Representative, Guardian, Conservator, or Other Successor Real Party in Interest:

_____ _____

[Signature] [Date]

_____

[Printed Name]

_____

[Title or Capacity]

_____ _____

[Witness Signature] [Date]

_____

[Witness Name]

(If Applicable) Name(s) and Signature(s) of Past, Present, and/or Future Spouse(s) From and after the Date of the Explosion:

_____ _____

[Signature] [Date]

_____

[Printed Name]

_____ _____

[Witness Signature] [Date]

_____

[Witness Name]

(Optional) Name(s) and Signature(s) of Attorney(s) Other Than Executing Counsel Evidencing Limited Joinder in Agreement:

_____

_____

_____

Notice address(es) of Participating Claimant, Spouse(s), and/or Attorney(s) for purposes of the Settlement Agreement:

_____

_____

Fax: _____

Email: _____

_____

_____

Fax: _____

Email: _____

_____

_____

Fax: _____

Email: _____

Approved: _____

Settlement Administrator

ATTACHMENT 8 TO CLAIM FORM:

SUMMARY OF MATRIX COMPUTATIONS

Pensacola Jail Fire Settlement
Claimant Net Payment Grid

May 4, 2017

Non-Gravely Injured Claimants

Represented/Pro Se and Scored Claimants (A)

First Responder		# of Claimants	Amount	Total
Cat 1	Inmate	4	$ 500.00	$ 2,000.00
	Other	215	$ 1,530.00	$ 328,950.00
Cat 2	Inmate	3	$ 1,200.00	$ 3,600.00
	Other	72	$ 3,440.00	$ 247,680.00
Cat 3	Inmate	0	$ 2,700.00	$ -
	Other	80	$ 6,870.00	$ 549,600.00
Cat 4	Inmate	6	$ 5,400.00	$ 32,400.00
	Other	17	$ 15,420.00	$ 262,140.00
Cat 5	Inmate	2	$ 12,000.00	$ 24,000.00
	Other	16	$ 30,870.00	$ 493,920.00
Cat 6	Inmate	5	$ 24,000.00	$ 120,000.00
	Other	18	$ 69,600.00	$ 1,252,800.00
Cat 7	Inmate	8	$ 60,600.00	$ 484,800.00
	Other	0	$ 114,850.00	$ -
		6	$ 100,000.00	$ 600,000.00
		452		$ 4,401,890.00

Represented/Pro Se and not Scored Claimants (B)

First Responder		# of Claimants	Amount	Total
Cat 1	Inmate	0	$ -	$ -
	Other	16	$ 1,530.00	$ 24,480.00
Cat 2	Inmate	1	$ 1,200.00	$ 1,200.00
	Other	5	$ 3,440.00	$ 17,200.00
Cat 3	Inmate	0	$ 2,700.00	$ -
	Other	6	$ 6,870.00	$ 41,220.00
Cat 4	Inmate	1	$ 5,400.00	$ 5,400.00
	Other	1	$ 15,420.00	$ 15,420.00
Cat 5	Inmate	0	$ 12,000.00	$ -
	Other	1	$ 30,870.00	$ 30,870.00
Cat 6	Inmate	1	$ 24,000.00	$ 24,000.00
	Other	1	$ 69,600.00	$ 69,600.00
Cat 7	Inmate	1	$ 60,600.00	$ 60,600.00
	Other	0	$ 114,850.00	$ -
		1	$ 100,000.00	$ 100,000.00
		35		$ 389,990.00

	Represented and Scored [A]	Represented/Pro Se and not Scored [B]	Not Represented and Not Scored [C]	Total	
Net Revenue for Non-Gravely Injured Claimants	$ 5,389,650.00	$ 4,401,890.00	$ 389,990.00	$ 597,770.00	$ 5,389,650.00
Net Extraordinary Damages	$ 206,489.00	$ 168,646	$ 14,941	$ 22,902	$ 206,489.00
Total Net Payments	$ 5,596,139.00	$ 4,570,535.81	$ 404,931.35	$ 620,671.85	$ 5,596,139.00
Three Gravely Injured Claimants	$ 8,369,661.00	$ 8,369,661.00			$ 8,369,661.00
Legal Fees (other than the 3 Gravely Injured), Admin Fees, and Advance Payments	$ 3,534,200.00	$ 3,245,820.15	$ 147,986.68	$ 140,393.17	$ 3,534,200.00
	$ 17,500,000.00	$16,186,016.96	$ 552,918.03	$ 761,065.02	$ 17,500,000.00 Grand Total for A + B + C

ATTACHMENT 9 TO CLAIM FORM:

CLAIMANT SCORING AGREEMENT

THE POTENTIAL PENSACOLA JAIL EXPLOSION SETTLEMENT
ATTN: ED GENTLE, SETTLEMENT ADMINISTRATOR
SUITE 100
501 RIVERCHASE PARKWAY EAST
BIRMINGHAM, ALABAMA 35244
1-205-716-3000
Pensacolasettlement@gtandslaw.com

CLAIMANT SCORING AGREEMENT

_____ (Claimant) and _____ (the Claimant's Spouse if applicable) agree to the Claimant's Score under the proposed Settlement Grid being in Category _____, with Extraordinary Damages of $_____ with an estimated total payment to the Claimant after the payment of estimated legal and administrative fees and expenses and other expenses of $_____.

However, the above amount is the best estimate available and may vary upon payment to me. I also understand that it may be reduced by any lien amounts I owe, such as Workers Comp, Medicare, Medicaid, or private insurance carrier liens, or child support or restitution liens.

I(We) agree to sign reasonable additional documents to carry out the Settlement.

THE UNDERSIGNED HEREBY SWEARS UNDER PENALTY OF PERJURY THAT ALL OF THE INFORMATION PROVIDED HEREIN IS TRUE AND ACCURATE.

CLAIMANT'S NAME: _____
[PRINT CLAIMANT NAME]

X_____ **DATE:**_____
SIGNATURE OF CLAIMANT

NOTARIZATION OF CLAIMANT SIGNATURE

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned, a notary public in and for said County and State, personally appeared _____ and acknowledges that he/she signed the foregoing, and that the foregoing is true and correct to the best of his/her knowledge and belief.

SWORN TO AND SUBSCRIBED before me this ___ day of _____, _____.

_____
Notary Public
My Commission Expires:

[SEAL]