



September 11th
Victim Compensation Fund

OMB 1105-0092

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Decedent's SSN or National ID Number

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Personal Representative's SSN or National ID Number

ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

A. PRIVACY ACT NOTICE

The U.S. Department of Justice is authorized to collect this information by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for and the amount of compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

I Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Signature of Personal Representative

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Date (mm/dd/yyyy)

Print Name



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B. PROOF OF DISMISSAL OF ANY LAWSUIT

Have you or any dependent, spouse, or beneficiary of the Decedent filed a lawsuit (or been a party to a lawsuit) in any Federal or State court relating to or arising out of damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal (other than a lawsuit to recover collateral source obligations or a lawsuit against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act)?

Yes No

• If Yes,

Was the lawsuit withdrawn or dismissed on or before January 2, 2012? Yes No

Was the lawsuit settled on or before January 2, 2011? Yes No

Was the lawsuit settled in part on or before January 2, 2011? Yes No Do not know

If yes,

Was the portion of the lawsuit that was not settled on or before January 2, 2011 dismissed on or before January 2, 2012? Yes No

You must initial here:



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C. ACKNOWLEDGEMENT OF WAIVER OF RIGHTS

I **hereby acknowledge** that by submission of a substantially complete Eligibility Form, I am **waiving** the right to file a lawsuit (or be a party to a lawsuit) in any federal or state court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001 or for damages arising from or related to debris removal.

Please note this Waiver of Rights could apply to the rights of individuals other than the Personal Representative. This waiver does not apply to lawsuits to recover collateral source obligations or to a lawsuit against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist attack.

Date (mm/dd/yyyy)

Date (mm/dd/yyyy)

Signature of Personal Representative

Print Name



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ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

D. AUTHORIZATION OF RELEASE OF INFORMATION

I Authorize the U.S. Department of Justice to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) for the purpose of evaluating my claim for compensation to the VCF from individuals, employers, hospitals, medical service providers, other federal, state or local agencies including the Social Security Administration and the Internal Revenue Service, the World Trade Center Health Program (WTCHP), the National Institute for Occupational Safety and Health (NIOSH), the Clinical Centers of Excellence under the WTCHP, the Nationwide Network of health care providers under the WTCHP, the Fire Department of New York, the New York Police Department, the New York Office of Payroll Administration, the New York City Employees' Retirement System, the Teachers' Retirement System of the City of New York, the New York City Police Pension Fund, the New York Fire Department Pension Fund, the New York City Board of Education Retirement System, the New York State Workers' Compensation Board, the State of New Jersey Department of Labor and Workforce Development, Division of Workers' Compensation, the State of Connecticut Department of Social Services, Bureau of Rehabilitation Services (formerly the State of Connecticut Workers' Compensation Commission), the Port Authority of New York and New Jersey, Office of Chief Medical Examiner of the City of New York, New York City Health and Hospitals Corporation, Child Health Plus, Family Health Plus, Medicaid, the WTC Captive Insurance Company, Inc., the Allocation Neutral for the World Trade Center Litigation Settlement, or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the Decedent whom I represent. The requested medical information may consist of the Decedent's entire medical records, which may include application or enrollment information, eligibility information, claims records, claim status, patient medical records, patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers. Disclosure requested will include otherwise confidential information. If records include claims or other information pertaining to chronic diseases, behavioral health conditions, including alcohol or substance abuse, communicable diseases, including HIV/AIDS, and/or genetic marker information, these records will be included in the information made available to the Victim Compensation Fund.

I Recognize that signing this Authorization is voluntary and that the Decedent's doctors and medical providers and any other entity in possession of Decedent's health information may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. However, the VCF may not be able to evaluate my claim if I do not authorize the release of the Decedent's medical records.

I Further Recognize that health care providers are required by the Privacy Rule under HIPAA to protect the Decedent's health information. When they provide the information to the VCF it will not be protected by this same Privacy Rule. However, the VCF, DOJ and NIOSH will continue to protect the confidentiality of the Decedent's medical records to the extent they are permitted to do so under another federal law, the Privacy Act. The VCF will not disclose the Decedent's identifiable health information that it receives under this Authorization without my written consent except where authorized to do so by law.

I Further Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

I Further Authorize the U.S. Department of Justice to publish the name of the Personal Representative filing a claim and the name of the Decedent for whom compensation is sought.

I Further Authorize the release of information relating to my claim, where such information indicates a violation or potential violation of law, including submission of fraudulent claims, to any civil or criminal law enforcement authority or other appropriate agency charged with responsibility of investigating or prosecuting such a violation.

I Further Authorize individuals, entities, and federal, state and local agencies including NIOSH and the WTCHP, having information pertinent to my claim to release such information to a duly accredited representative of the U.S. Department of Justice during the review of my claim to the Victim Compensation Fund, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that VCF and the entities listed above have already acted based on this Authorization. I understand that to revoke this authorization, I must write to the VCF at September 11th Victim Compensation Fund, P.O. Box 34500, Washington, D.C. 20043. I recognize that this authorization is valid for six (6) years from the date signed or upon my written termination whichever is sooner.

I Certify that I am the person named below (Personal Representative making a claim to the Victim Compensation Fund on behalf of the Decedent) and I authorize the release of information listed above. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense subject to a \$5,000 fine.

By initialing, I acknowledge that the information described above may include mental health information and I authorize the release of such information.

Initial here:

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Date (mm/dd/yyyy)

Signature of Personal Representative

Print Name

2405394007



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Personal Representative's SSN or National ID Number

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ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

E. PERSONAL REPRESENTATIVE'S ACKNOWLEDGMENT OF ATTORNEY'S COMPLIANCE WITH LIMITATION ON ATTORNEY FEES

If an attorney has rendered services in connection with this claim, the Personal Representative must sign and date the following acknowledgement:

I hereby acknowledge that I have read and understand the provisions governing the limitation on attorney fees as stated in the Instructions to this claim form, which, in general and with limited exceptions, provide that my attorney, notwithstanding any contract, **cannot charge me more than ten percent (10%) of any award that may be paid on my claim**, and that any expenses incurred by my attorney in connection with my claim, other than those that are routinely incurred, cannot be charged to me unless they have been approved by the Special Master.

Signature of Personal Representative

____ / ____ / _____

Date (mm/dd/yyyy)

Print Name



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F. AUTHORIZATION FOR ATTORNEY COMMUNICATION AND CORRESPONDENCE

If an attorney or other authorized individual is assisting the Personal Representative with this claim and the Personal Representative wants to authorize the Victim Compensation Fund to communicate with this individual, please sign and date the following authorization.

I Authorize the Special Master, the Special Master's designees, the United States Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact my attorney or other persons authorized to act on my behalf (if identified in Part I.C.) if the Special Master needs additional information or clarification about my claim.

Signature of Personal Representative

____ / ____ / _____

Date (mm/dd/yyyy)

Print Name



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ATTESTATIONS AND CERTIFICATIONS FOR ELIGIBILITY FORM

G. CERTIFICATION OF ACCURACY OF INFORMATION

I hereby certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I agree that any payment made by the VCF is expressly conditioned upon the truthfulness and accuracy of the information and documentation provided in support of the claim. Further, I understand that false statements or claims made in connection with this application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this

 day of

, 201.

Signature of Personal Representative

Print Name



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H. PAPERWORK REDUCTION ACT NOTICE

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. The estimated average time to complete and file this application is 1.5 hours. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-0092. (Do not mail your completed application to this address.)