September 11th
Victim Compensation Fund

Signature Page

OMB No: 1105-0092

Victim's SSN or National ID Number:

Instructions: Please review the following statements and initial where indicated. Sign and date the form, and print your name at the end of the form.

For all claimants, please initial in acknowledgement of the following:

Initials

I Understand the submission of this claim authorizes the Department of Justice to collect this information under the Privacy Act and I have read and understand the Privacy Act Notice provided. Consistent with that Notice, **I Consent** to the disclosure of any records or information relating to my Victim Compensation Fund claim for the routine uses described in that Notice, and I **Further Authorize** such disclosures 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.

Initials

I 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 declare under penalty of perjury that the foregoing is true and correct. **I Understand** that false statements or claims made in connection with the application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, including as provided in 18 U.S.C. § 1001, 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.

Initials

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; 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 individual whom I represent. **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 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.

For claimants with an attorney or other authorized representative or alternative contact, please initial in acknowledgement of the following:

Initials

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.

For claimants filing on behalf of a deceased individual, please initial in acknowledgement of the following:

Initials

I Certify that I have provided the required Notice of Filing of Claim to all of the decedent's living relatives and potentially interested parties by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided. **I also Authorize** the U.S. Department of Justice to publish my name as well as the name of the deceased individual on whose behalf I am seeking compensation.

Signature of Claimant or Authorized Representative

Date of Signature (mm/dd/yyyy)

Print Name