



Instructions – Personal Injury Compensation Form

This claims process was established under the September 11th Victim Compensation Fund, part of legislation passed by Congress and signed into law by the President. The Fund provides compensation to individuals who were physically injured or the families and beneficiaries of individuals who were killed as a result of the terrorist-related attacks of September 11, 2001. The United States Department of Justice and the Special Master issued final regulations to implement this fund on March 7, 2002. Both the United States Department of Justice and the Special Master are committed to ensuring that this program is administered expeditiously, fairly, and in a manner that is sensitive to the needs of those who have suffered as a result of the attacks. To help accomplish these goals, assistance will be made available to all claimants to help them complete this claims process and obtain any and all benefits that will be available to eligible claimants under this fund.

These instructions are designed to help you complete and submit the Personal Injury Compensation Form. If you are a Personal Representative for a Victim who was killed as a result of the September 11th attacks, you should use the instructions for the Compensation Form for Deceased Victims.

Please remember to include the Victim's Social Security or National Identification Number at the top of each page and attach any additional pages.

Where can I go for more information?

Through the Internet – The Victim Compensation Fund web site address is:

www.usdoj.gov/victimcompensation

By telephone –

The Fund is closed.

In person – You can go to one of several Claims Assistance Sites. Because their locations and hours of operation are subject to change, please call the Helpline or visit the website to find the nearest location, directions, and current hours of operation.

Introduction

What is the September 11th Victim Compensation Fund?

The Fund was established by Congress as part of Public Law 107-42 and designed to bring financial relief to those most devastated by the events of September 11th. Specifically, it provides compensation to:

- Individuals who suffered physical harm as a result of the terrorist attacks
- The beneficiaries and families of those killed as a result of the terrorist attacks

Your participation in the Fund is voluntary. The Fund provides a no-fault alternative to tort litigation. By participating in the Fund process, claimants waive their rights to bring such litigation.

What is included in the Personal Injury Compensation Form?

The Compensation Form has four parts:

Part I – Eligibility and Application for Advance Benefits: This identifies the Victim and establishes eligibility requirements. This part also allows you to elect for Advance Benefits against the final award.

Part II – Compensation

Information: This addresses the information and documentation the Special Master needs to calculate the award.

Part III – Attestations and

Certifications: This part includes your authority for release of information contained in the Compensation Form and your certification that the information in the Compensation Form is true, accurate, and complete.

Part IV – Supporting

Documentation Checklist: This checklist identifies the supporting documentation that you must submit with the Compensation Form.

Who should complete the Personal Injury Compensation Form?

Victims who were physically injured as a result of the terrorist-related aircraft crashes of September 11, 2001 and wish to submit a claim to the fund.

Do I use the Compensation Form to apply for Advance Benefits?

Yes. Injured Claimants hospitalized for one week or longer are eligible for Advance Benefits. You can apply in Part I. If you already submitted the earlier version of the *Eligibility Form and Application for Advance Benefits* and did not apply for Advance Benefits through that form, you can use this Compensation Form to apply now.



Where should I mail my completed Compensation Form?

Completed Compensation Forms should be mailed to the following address:

By regular mail:

The Fund is closed.

By overnight mail:

The Fund is closed.

General instructions

- Please read all instructions carefully before completing the form.
- Review the Checklist in Part IV for the documents that you will need to provide with your form.
- Include your Social Security Number or National Identification Number at the top of all pages of the form, and on all additional pages or documents you submit.
- Complete all sections of the Compensation Form. Otherwise, the Special Master will not be able to calculate the compensation award.
- Have a Notary Public (or equivalent if you do not live in the U.S.) notarize your signature in Part III.e – Attestations and Certifications.
- Please make a copy of your completed Compensation Form before you mail it. The Special Master's office may need to contact you for clarification or

additional information based on what you submitted.

- Mail your completed Compensation Form so that it is postmarked no later than December 21, 2003.
- Please send a letter or call the Victim Compensation Fund Helpline if you change your address and/or telephone number between now and December 21, 2003. If the Special Master has questions and cannot locate you, your claim may be deemed abandoned at the end of the program, which is December 21, 2003.

What should I do if I already submitted the form entitled *Eligibility Form and Application for Advance Benefits*?

This Personal Injury Compensation Form replaces and supplements the earlier version of the *Eligibility Form and Application for Advance Benefits*. It should be used for all physical injury claims submitted after March 24, 2002. If you submitted the earlier document, you will not have to resubmit information you already provided. However, you will need to do the following:

- Part I – Please provide the claim number. Also, if you did not apply for Advance Benefits in your previous submission and you wish to do so now, please so indicate in Part I.f. Otherwise, you can skip the rest of Part I.
- Part II – Please complete all questions.
- Part III – Please initial, sign, and notarize this part.
- Part IV – Please identify all supporting documentation you are submitting.

- If you choose to participate in this program, you waive certain rights to litigate. This waiver could

apply to the rights of individuals other than you. This waiver does not apply to a civil action to recover collateral source obligations or to a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.

Claims by Non-U.S. Citizens or Residents

- If you do not have a U.S. Social Security Number, you must provide your country's equivalent identification number (such as a national tax identification number). This number will be used to track your claim.
- A Notary Public or equivalent for your country must notarize your signature.
- Please list the amounts for medical expenses, loss of earnings, and collateral source compensation in whatever currency they were or will be earned or paid.
- Unless you have a U.S. bank account, the award will be paid to you in U.S. dollars via a check from the U.S. Department of the Treasury. It will be mailed to the address you provide in Part I.a.

Section-by-section instructions

These instructions provide an overview of the questions in each section, provide more detail on certain questions, and identify the supporting documentation that you must include with your Compensation Form.



Part I – Eligibility and Application for Advance Benefits

Part I.b – Information about Victim's Circumstances on September 11, 2001

This section asks for information about you:

- Were you a rescue worker?
- Where were you injured (please check "other" and provide information if you were injured somewhere other than at the Pentagon or the World Trade Center)

The regulations require that you were present at the site at the time of the aircraft crashes or in the immediate aftermath.

Present at the site (the World Trade Center, Pentagon, or Shanksville) means physically present at the time of the crashes or in the immediate aftermath:

- i) In the buildings or portions of buildings that were destroyed as a result of the airplane crashes; or
- ii) In any area contiguous to the crash sites that the Special Master determines was sufficiently close to the site that there was a demonstrable risk of physical harm resulting from the impact of the aircraft or any subsequent fire, explosions, or building collapses.

Immediate aftermath means the following:

- In general – the period of time from the crashes until 12 hours after the crashes
- For rescue workers – the period of time from the crashes until 96 hours after the crashes

What is the definition of physical harm?

To document eligible physical harm you must provide proof of a *physical* injury to the body that was treated by a medical professional:

- Within 24 hours of the injury having been sustained or within 24 hours of rescue. However, Victims who were unable to realize immediately the extent of their injuries or did not have appropriate care available on September 11th are eligible if medical treatment was sought within 72 hours of the injury having been sustained or within 72 hours of rescue. The Special Master has discretion to extend the time period even further on a case-by-case basis for rescue personnel who otherwise meet this requirement, but did not seek medical treatment within 72 hours.

AND

- You must show that the injury either
 - Required hospitalization as an inpatient for at least 24 hours, **or**
 - Caused, either temporarily or permanently, partial or total physical disability, incapacity, or disfigurement.

The Special Master cannot compensate those who suffered only emotional harm. Also, the Fund cannot cover those who face only a risk of future injury (i.e., a latent injury that does not fully manifest itself within the two year statutory time period for the Fund).

Part I.c – Information about the Victim's Physical Injury

You need to indicate whether your injury caused temporary or permanent, partial or total, disability, disfigurement, or incapacity.

TIP! For certified medical records contact the medical provider directly and request certified copies.

Please describe your injury and provide **certified** medical records created by or at the direction of the medical professional who provided you the medical care. This would include medical records of hospitals, clinics, physicians, licensed medical staff, or registries maintained by Federal, State, or local governments.

How will disability be defined?

Temporary disability – The Special Master may consider evidence regarding the length of time the Victim was absent from his or her employment. The Special Master will be guided by the definition of temporary disability employed in disability programs or by private insurers.

Permanent disability – The Special Master will make a determination regarding whether the Victim is capable of performing his or her usual profession in light of his or her injuries.

Total permanent disability – The Special Master may accept a determination of disability made by the Social Security Administration without further medical evidence or review. He may also consider the determination of permanent disability made by other government agencies or private insurers in evaluating the claim. The Special Master may require an evaluation of the Victim's disability and ability to perform his or her occupation from medical experts.

Part I.d – Information about the Victim's Guardian

If the Victim is a minor or is incapacitated, information on the guardian or other authorized legal



representative should be provided here.

Please provide the person's name, address, telephone number, and name of the firm (if applicable).

Part I.e – Information about the Victim's Attorney or Other Authorized Individual

You are not required to have a lawyer to file a claim. However, you have the right to be represented by an attorney and you should be aware that you will be waiving and affecting rights to file lawsuits by your submission of a claim.

Please complete this section if you are represented by counsel and indicate if you want either your attorney or another person to deal with the Special Master's office regarding questions about your claim (instead of contacting you directly).

Part I.f – Advance Benefits Election

Advance Benefits is a payment of \$25,000 available to a physically injured Victim facing financial hardship who was hospitalized for one week or longer. The Special Master deducts the Advance Benefits from the final compensation award.

Please indicate if you wish to apply for Advance Benefits. There are two criteria for Advance Benefits eligibility:

- You must have been hospitalized for at least one week (answer this in Part 1.c)

AND

- You have not yet received an amount in excess of your lost wages plus out-of-pocket medical expenses from other sources (Money received from privately-funded charitable entities should

not be included when calculating this amount).

Method of Payment of Advance Benefits

Please make an election for how you wish to receive the Advance Benefits payment. If you elect direct deposit, enclose the requested financial institution information and attach a voided check.

Acknowledgement of Waiver of Rights

You must acknowledge your understanding that by submitting a substantially complete Eligibility Part I Eligibility and Application for Advance Benefits Form and requesting Advance Benefits you are waiving the right to file a civil action (or be a party to an action) 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. This Waiver of Rights could apply to the rights of individuals other than you. This waiver does not apply to other civil actions to recover collateral source obligations or a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.

You must sign that you read and understand this acknowledgement.

Part II – Compensation Information

You must complete all sections of Part II. Otherwise, the Special Master will not be able to calculate your compensation. The compensation will be the sum of the economic loss and the non-economic loss minus collateral offsets.

The **economic loss** will vary depending on the following:

- Loss of earnings or other benefits related to employment because of disability
- Medical expense loss
- Replacement services loss

The Victim's **non-economic loss** will be based on the nature of the injury and non-economic harm.

Please note: The Special Master has not published a table, list, or chart of presumed economic or non-economic loss for injured Victims because the amount will have to be determined in part based on the duration and amount of disability, incapacity, or disfigurement. A Victim who is totally or permanently disabled may look at the presumed awards chart for some guidance as to economic loss.

The Special Master will reduce the loss by the present value of the **collateral source offsets**. These are discussed in more detail in Part II.h.

Part II.a – Selection of Claims Processing Track

You can choose one of two tracks to adjudicate (process) your claim. You must submit a completed Compensation Form and all the supporting documentation, regardless of which Track you select:

Track A has two steps. In Step 1, the claim is reviewed and a presumed award is calculated. Step 2 is optional. In Step 2, you can request a hearing and have the presumed award reviewed. You can present additional information at the hearing.

Track B has one step. The claim is presented at a hearing, after which the award is calculated. You must submit all information before the hearing is held. You cannot submit additional information after the



hearing, although you may offer witnesses to testify at the hearing.

Part II.b – Victim's Employment History

This section asks you to provide information about the Victim's employment. Please describe your employment since September 11, 2001. For employment before September 11, 2001, please describe your employment starting with the most recent employment information and work backwards to 1999.

Part II.c – Dependents not Listed

The number of dependents directly impacts the economic loss and the non-economic loss calculation. The Special Master will be able to identify most of the Victim's dependents from the Victim's 2000 United States Federal tax return or other nation's national tax return.

You should list any of the Victim's dependents not listed on the 2000 Federal/national tax return. These would include a child born or adopted on or after January 1, 2001, children listed on the tax return of the Victim's spouse if the couple filed their taxes separately, any another person who became a dependent on or after January 1, 2001, or any other dependents who could have been, but were not claimed as a dependent on the Victim's 2000 return.

Part II.d – Insurance Information

Please provide information on any insurance policies under which the injured Victim is covered.

Part II.e – Victim's Medical Loss

The Special Master will review your non-reimbursed medical expenses and loss of earnings to determine your economic loss.

You should describe and document non-reimbursed **medical expenses** (i.e., not covered by health insurance) that were incurred as a result of the physical injury. You should also describe any anticipated **future medical expenses** that are not reimbursable associated with the injury you sustained as a direct result of the September 11th aircraft crashes. If you are a military or government employee, indicate what medical program or coverage you are eligible for.

Please remember that the Special Master cannot reimburse you for latent injuries – injuries that have not manifested at the time of the claim.

Part II.f – Victim's Loss of Earnings To Date

This section also asks you to describe and document **your loss of earnings** – the actual amount of work you missed without compensation (i.e., you were not paid for these days of missed work). You may also provide information about any claimed loss of business or employment opportunities.

All claimants who have lost earnings and who expect to have significant lost earnings in the future as a result of their injuries and disability should provide the compensation data and employer provided benefit information requested in Part II.g.

Part II.g – Victim's Loss of Future Earnings

Complete this section only if you are suffering an ongoing disability or are seeking compensation for loss of future earnings.

This section asks you to describe and document any claimed **future loss of earnings** – the amount of work you will miss without

compensation or reduction in earnings.

Compensation Information for Disabled Claimants

The Victim's compensation award will be based, in part, on earned income. This includes base salary and wages, bonus, commission, overtime, or incentive pay, and certain other employer provided benefits. This does **not** include passive income such as investments or rentals.

Claimants should feel free to contact the Helpline or the Claims Assistance Centers to get assistance in this process.

Please enter the Victim's pre-tax **base salary and wages** for 1999, 2000, 2001, and 2002. Indicate how the salary was paid and attach supporting documentation. Documentation could include pay stubs, salary letters, or end of year pay statements.

Some Victims received **additional sources of compensation**, such as bonuses, commissions, overtime, tips, honoraria, or other incentive pay. The Special Master will consider these when determining total compensation. Please describe and provide information for each additional source of compensation the Victim received in 1999, 2000, 2001, and 2002.

If the Victim was self-employed or a business owner, please provide compensation details with the form at Part II.i.

Employer-Provided Benefit Information

Any eligible Victim who lost earnings and who expects to lose earnings in the future as a result of the injuries should provide information on their employer provided benefits. In addition to



base salary and other sources of compensation, many Victims received benefits provided by their employers. The amount of certain benefits will be considered with the compensation information to calculate the economic loss. The most common benefits include the following:

- Health benefits
- Pension
- Employer contribution to Victim's 401(k) or similar plan
- Housing allowance
- Transportation subsidy or company car
- Military benefits
- Government employee benefits
- Other- such as profit sharing plans

Please provide details on benefits the Victim received from his/her employer in 2000 and 2001. Some benefits are provided as a dollar amount (such as medical benefits), and some are provided as a percentage of income (such as 401(k) contributions). Please indicate how the employer provided these benefits.

Military housing allowances should be included under the compensation section, instead of the benefit page.

The Special Master will need a variety of supporting documents for this section. Please see the Document Checklist for help determining what documents to include. Employers can be contacted for additional information on benefits provided.

The Special Master recognizes that collecting this information may be a difficult task. Please contact the Helpline or the Claims Assistance Centers if you need further assistance or guidance.

Part II.h – Collateral Source Compensation

When Congress created the Victim Compensation Fund, it legislated that the compensation award be reduced by **collateral source compensation**. These include benefits you received or are entitled to receive related to the terrorist – related aircraft crashes of September 11, 2001.

Please describe **any Social Security** benefits you have received, are currently receiving, or have applied to receive from the Social Security Administration as a result of your injury. Please provide a copy of documentation from the Social Security Administration stating your eligibility and benefits.

Please describe **any worker's compensation** payments you have received, are currently receiving, or are entitled to receive as a result of your injury. Please provide a description of your worker's compensation benefit program or coverage. This information should be available from your employer or union (if your employer or union provided the program) or from your insurance agent (if you purchased worker's compensation insurance independently).

Finally, please describe **any other payments** you received, or are entitled to receive. Please provide a copy of appropriate documentation.

Please note: Contributions from privately funded charitable entities to you or your family, will **not** be deducted as a collateral source component.

Part II.i – Other Information (optional)

Please use this section to provide any additional information you believe is relevant to the calculation of compensation. This might include clarification of information you provided elsewhere in the

Compensation Form or information not covered elsewhere, including information relevant to the determination of economic and non-economic loss.

Please remember to put your Social Security Number/ National Identification Number at the top of each page of additional information you attach to your Compensation Form.

Part III – Attestations and Certifications

This Part contains a series of important certifications and authorizations you must make. Please take sufficient time to read and understand each of them. They cover the information you submit in and with your claim. You must also have your signature notarized in the space provided.

Part III.b – Certification of Dismissal from Any Legal Action

Participation in the Victim Compensation Fund is voluntary. To participate, however, you must certify that you have not filed a civil action (or been a party to an action) 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. This does not apply to other civil actions to recover collateral source obligations or a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.

If you or your spouse or any of your dependents have already filed a civil action (or were party to an action), you must indicate if this civil litigation action was dismissed by March 21, 2002, and you must attach proof of the dismissal.



Part III.c – Acknowledgement of Waiver of Rights

You must acknowledge that, by submitting a substantially complete Personal Injury Compensation Form claim, you **are waiving the right** to file a civil action (or be a party to an action) 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. This waiver could apply to the rights of individuals other than you. This waiver does not apply to other civil actions to recover collateral source obligations or a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.

Part III.d – Authorization for Release of Information

You must authorize the release of information relating to your claim so that the Special Master can review, verify, and process your claim. This authorization allows the U.S. Department of Justice and the Special Master to do the following:

- Obtain information from third parties, such as professionals who provided medical treatment
- Disclose information relating to your claim to other Federal, State, or local agencies, such as the U.S. Department of the Treasury; or other entities having information related to your claim, such as your employer(s) and insurer(s)
- Publish your name as a claimant on the Victim Compensation Fund website, at www.usdoj.gov/victimcompensation
- Release information on you and your claim to law enforcement authorities if there is evidence of fraud
- Allow the U.S. Department of Justice to provide released information to duly accredited

representatives of the Department during the review of your claim

- Contact your attorney or other individual (identified in Part I.d and I.e) for more information on your submission, if necessary.

Your authorization is valid for five years from the date of your signature, or upon your written termination, whichever is sooner.

Part III.e – Notarized Certification of Accuracy of Information

You must certify that the information contained in and attached to the Compensation Form is true and accurate. The Special Master will use procedures to verify, authenticate, and audit claims. False statements may result in fines, imprisonment, and/or any other remedy available by law. The Special Master shall refer all evidence of false or fraudulent claims to the Department of Justice and other appropriate law enforcement authorities.

What is a Notary Public? What does “notarization” mean?

A Notary Public is a person authorized by the state to notarize certain documents. To notarize means to witness a person signing a document. In New York State, for example, Notary Publics are commissioned in their counties of residence. There is a small fee to notarize a document.

TIP! Please remember to wait and sign the Certification in front of the Notary Public. If you sign the form before you see the Notary Public, you will have to re-sign the form so that the Notary Public can witness your signature.

Part IV – Supporting Documentation Checklist

As noted throughout the Compensation Form, you must submit supporting documentation.

The Special Master developed this checklist to help you prepare and submit a complete Compensation Form. Please use it to collect the required documentation. Please describe all documents you submit (if they are not already listed in the checklist). Unless noted otherwise, you must submit documentation for all Parts. Finally, please submit the completed checklist with your Compensation Form.

Exhibit A – Authorization for Release of Medical Records

You need to submit a completed copy of **Exhibit A, Authorization for Release of Medical Records** with the Personal Injury Compensation Form. This exhibit contains an authorization for all doctors and health care providers to release the medical records of the Victim. Please sign this authorization and attach it with your completed Compensation Form.

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 which impose the least possible burden on you. The estimated average time to complete and file this application is 15 hours. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to

The Fund is closed.



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part I - Eligibility and Application for Advance Benefits**

Victim's SSN or Nat'l ID #:

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PLEASE COMPLETE THIS FORM BY TYPING OR PRINTING IN CAPITAL LETTERS

If you have previously submitted an *Eligibility Form and Application for Advance Benefits*, please enter your Claim Number here [Claim # _____] and proceed directly to Part II.

Part I. a - General Victim Information

Victim's Last Name											
First Name						Middle Name					
Street Address Line 1											
Street Address Line 2											
Apartment Number			City						State/Province		
ZIP/Postal Code			Country								
Passport Country (if not U.S.)						Passport Number (if not U.S. and if available)					
Country of Citizenship						Victim's Date of Birth (mm/dd/yyyy)					
Telephone Number (day)						Telephone Number (evening)					

Part I. b - Information about Victim's Circumstances on September 11, 2001Was the Victim a rescue worker? Yes ☐ No ☐**Location of the Victim at time of injury (choose one)**

- ☐ Pentagon
- ☐ World Trade Center
- ☐ Public Street near WTC (Please provide address/cross-streets)

Date and Time of Injury

								A.M. ☐
Date (mm/dd/yyyy)						Time (hour)		P.M. ☐

☐ Other



September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part I - Eligibility and Application for Advance Benefits

Victim's SSN or Nat'l ID #:

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Part I. c - Information About the Victim's Physical Injury

Was the Victim treated by a medical professional within 24 hours
of being injured or rescued?

Yes ☐ No ☐

If No, was the victim treated within 72 hours?

Yes ☐ No ☐

Please provide an explanation for the delay in treatment if not treated within 24 hours:

Did the Victim's injury require hospitalization for at least 24 hours?

Yes ☐ No ☐

If Yes, how many days?

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Did the physical injury cause incapacity?

Yes ☐ No ☐

Did the physical injury cause disfigurement?

Yes ☐ No ☐

Did the physical injury cause disability?

Yes ☐ No ☐

If yes, is the disability partial or total?

Partial ☐ Total ☐

Is the disability temporary or permanent?

Temp. ☐ Perm. ☐

Please briefly describe the nature of the Victim's physical injuries and attach certified copies of all supporting medical records.

☐ Note: if you need more space to answer Part I.c, check the box and continue on another copy of this page



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part I - Eligibility and Application for Advance Benefits**

Victim's SSN or Nat'l ID #:

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Part I. d - Information About the Victim's Guardian (If Applicable)

If someone other than the injured Victim is submitting this claim as a guardian or other authorized legal representative, please complete the following (please read the detailed instructions for more information):

Representative's Social Security or National ID Number:

			-			-				
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Representative's relationship to Victim:

☐ Guardian ☐ Other explain _____

Representative's Last Name

First Name

Middle Name

Street Address Line 1

Street Address Line 2

Apartment Number

City

State/Province

Zip/Postal Code

Country

Telephone Number (day)

Telephone Number (evening)

Country of Citizenship

Do you want to allow this person to discuss this claim with the Special Master and/or the Victim Compensation Fund and receive related correspondence? Yes ☐ No ☐

Part I. e - Information about the Victim's Attorney or Other Authorized Individual (If Applicable)

If an attorney or other authorized individual is assisting the Victim with this claim, please check the applicable box and fill out the information below:

☐ Attorney ☐ Other Individual If other, explain _____

Attorney's Last Name

First Name

Middle Name

Firm Name (if applicable)

Street Address Line 1

Street Address Line 2

Suite Number

City

State/Province

Zip/Postal Code

Country

Telephone Number (day)

Telephone Number (evening)

Do you want to allow this person to discuss this claim with the Special Master and/or the Victim Compensation Fund and receive related correspondence? Yes ☐ No ☐

Victim's SSN or Nat'l ID #:

Do you wish to apply for Advance Benefits?

Yes ☐ No ☐

If Yes, please continue below. If No, please skip to Part II.

- The payment will go to the Victim. Check one of the boxes below (direct deposit is generally the quickest way to receive payment).

- ☐ *Check* - Note that the check will be mailed to the address listed in Part I. a
- ☐ *Direct deposit/electronic fund transfer* (Available for U.S. banks only) - Note that payments will be wired to the account of the Victim only. **Please attach a copy of a voided check and fill out the information below.**

Account Number

☐ Savings

☐ Checking

ABA Routing Number - This number can be obtained by contacting your Financial Institution or can be located at the bottom of your checks. (Nine digit number preceding your account number.)

Name of Financial Institution

Street Address Line 1

Street Address Line 2

A horizontal number line with 11 tick marks. The first tick mark on the left is labeled "City".

State

Zip Code

Telephone Number



September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part I - Eligibility and Application for Advance Benefits

Victim's SSN or Nat'l ID #:

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Acknowledgement of Waiver of Rights (for Advance Benefits)

I hereby acknowledge that by submitting a substantially complete *Part I - Eligibility and Application for Advance Benefits Form* and requesting Advance Benefits, I am **waiving** the right to file a civil action (or be a party to an action) in any Federal or State court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001.

Please note this Waiver of Rights could apply to the rights of individuals other than the injured Claimant. This waiver does not apply to a civil action to recover collateral source obligations or to a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act.

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Signature of Claimant

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Date (mm/dd/yyyy)

Supporting Documentation - Please see the *Supporting Documentation Checklist* at the end of this form to identify the documents you need to send with your claim.



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

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The information requested in this part will help determine the value of the compensation award. Please answer each question in full. Use additional paper if you need more space. If you do so, please add the Victim's SSN or National ID # to each page as well as the Part number to which information is being added.

Part II. a - Selection of Claims Processing Track

Please select one of the adjudication tracks described below by checking a box. (Note that you must submit a completed claim package regardless of which track you choose.)

☐ Track A - This Track includes two steps. In step 1, the claim is reviewed and a presumed award is calculated by the Special Master. In step 2, the Victim may, at his/her option, accept the award or request a hearing to review the presumed award and to present additional information.

☐ Track B - In this Track, a hearing will be held to determine the amount of the award.

Part II. b - Victim's Employment History

Please provide your employment history from January 1999 to the present. Please note any changes in employer, job title, and/or job description during this period. If self-employed, write Self-Employed in the Employer Name and Address box.

Employment Since September 11, 2001:

Date Range	Employer Name and Address	Employer Phone #
/ / to / /		
Job Title and/or Description		

Employment between January 1, 1999 and September 11, 2001:

Date Range	Employer Name and Address	Employer Phone #
/ / to / /		
Job Title and/or Description		
Date Range	Employer Name and Address	Employer Phone #
/ / to / /		
Job Title and/or Description		
Date Range	Employer Name and Address	Employer Phone #
/ / to / /		
Job Title and/or Description		

☐ Note: if you need more space to answer Part II.b, check the box and continue on another copy of this page



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

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Part II. c - Dependents

Please attach a copy of your 2000 Federal/National Tax return (if you filed one) showing dependents listed.

Also, please list below any qualifying dependents that were **not** listed on your 2000 Federal/National Tax Return (such as children born or adopted after December 31, 2000 or children listed on the spouse's separately-filed return) and explain their relationship to the Victim.

Dependent's Name (First Middle Last)	Date of Birth (mm/dd/yyyy)	SSN or National ID Number	Relationship to Victim

☐ Note: if you need more space to answer Part II.c, check the box and continue on another copy of this page

Part II. d - Insurance Information

Please provide information on any insurance, health care or disability benefits under which the injured Victim is covered.

Insurance Type	Name of Carrier	Group or Individual	Policy or ID #
Major Medical		Group ☐ Individual ☐	
Union Benefits		Group ☐ Individual ☐	
Medicare		Group ☐ Individual ☐	
Medicaid		Group ☐ Individual ☐	
Disability Income Insurance		Group ☐ Individual ☐	
Workers Compensation		Group ☐ Individual ☐	
Other (please describe)		Group ☐ Individual ☐	
Other (please describe)		Group ☐ Individual ☐	
Other (please describe)		Group ☐ Individual ☐	
Other (please describe)		Group ☐ Individual ☐	

☐ Note: if you need more space to answer Part II.d, check the box and continue on another copy of this page



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

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Part II. e - Victim's Medical Loss

What amount of medical expenses directly attributable to the Victim's injury from the September 11th attacks were not paid for or reimbursed?

(Please provide currency if other than US Dollars _____)

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Medical Expenses Loss To Date - Please describe below any medical expenses not paid for or reimbursed including rehabilitation treatment, vocational training, home modification, assisted living and other such expenses.

Future Medical Expenses - Please describe below any anticipated future medical expenses that will not be paid for, reimbursed, or provided by a health care program (such as VA).

☐ Note: if you need more space to answer Part II.e, check the box and continue on another copy of this page



September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation

Victim's SSN or Nat'l ID #:

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Part II. f - Victim's Loss of Earnings To Date

Loss of Earnings - Please describe below any loss of earnings and/or other benefits from work already missed as a result of the injury (i.e. work missed for which you were not or will not be compensated). Attach documentation regarding uncompensated absences from work as a result of injury sustained on or as a result of the September 11th air crashes.

Replacement Services - Please describe below any household services to date that you have not been able to perform as a result of the injury. Include information about the cost of obtaining replacement services.

☐ Note: if you need more space to answer Part II.f, check the box and continue on another copy of this page

Victim's SSN or Nat'l ID #:

Three tens rods minus two tens rods minus four units cubes equals one ten rod and six units cubes.

Complete Part II.g only if you are suffering an ongoing disability or are seeking compensation for loss of future earnings.

If you claim permanent disability, ongoing temporary disability or if due to an incapacity you anticipate a loss of future earnings, please: 1) describe the nature of the disability or incapacity, and 2) state whether any government agency, insurer, or physician has made a determination with respect to your disability. Please attach any determination of your capacity to work in the future.

[illegible][illegible]

7663509286



September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation

Victim's SSN or Nat'l ID #:

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- 3) **Loss of Future Earnings** - If you suffer from an ongoing disability or incapacity, please describe below any anticipated loss of future earnings as a result of the injury. Please describe how this disability will affect your job in the future. Please also explain whether you were able to return to your previous employment or any other employment.

- 4) **Loss of Future Replacement Services** - Please describe below any future household services that you will be unable to perform as a result of the injury.

☐

Note: if you need more space to answer Part II.g, check the box and continue on another copy of this page



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

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5) Compensation Information for Disabled Claimants

If you are disabled and anticipate a loss of future earnings from your injury, please provide your complete compensation history below. Compensation typically includes base salary and wages as well as other sources of earned income such as commissions, bonuses, incentive pay, etc. Please note that passive sources of income, such as income from rental properties or investments, are not considered in the calculation. For salaried Victims please provide base salary at the end of each year. If the Victim was both employed and self-employed complete both lines. In addition, please provide copies of all tax return information (including W-2 forms and other attachments) for the 2000 tax year.

Compensation Amount

(Please provide currency if other than US Dollars _____)

Was the Victim self-employed? If yes, enter total yearly compensation amount here.

2002**2001****2000****1999**

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If not self-employed, enter **Base Salary/Wage** information here.

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Indicate whether figure provided is a yearly, monthly, bi-weekly, weekly, or hourly figure.

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Additional Compensation - Please provide information for all other compensation including, but not limited to, incentive pay, bonuses, overtime, tips, commissions, shift differentials, longevity, and honoraria.

For Victims who were in the armed forces - Please include housing, subsistence, TAD, re-enlistment, and other compensation by each category. However, if you want the Special Master to rely on published compensation and benefit scales please check the box at the end of this statement. If you do so, there is no need to complete this section, but please attach a copy of the Victim's Military Leave and Earnings Statement indicating the pay level and benefit information.

☐ I wish to rely on published data regarding U.S. military compensation.

2002**2001****2000****1999**

Other Compensation (Please describe)

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Other Compensation (Please describe)

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Other Compensation (Please describe)

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Other Compensation (Please describe)

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Other Compensation (Please describe)

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**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

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6) Employer Provided Benefit Information

In addition to the compensation information provided above, the compensation award for loss of future earnings will be based on certain employment benefits provided to the Victim by his/her employer. Please provide details on employer provided benefits received during the years 2000 and 2001.

	Total Benefits (Please provide currency if other than US Dollars _____)																															
	2001	2000																														
1. Health Benefits - Payroll deduction or cost of employer-provided health benefits to employee and any other covered persons (indicate who was covered):																																
☐ Victim only	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
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☐ Victim and One Dependent	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
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☐ Victim and Family	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
2. Pension Benefits - Attach (a) pension plan or pension section from employee handbook and (b) recent pension statement. Check one:																																
☐ Defined Benefit Plan (monthly pension payable at retirement) (indicate victim's hire date at last employer: ____/____/____)																																
☐ Defined Contribution Plan (employer contribution each pay period) (indicate employer contribution as % of salary: ____%)																																
3. Employer Matching Contribution to 401(k)/403(b)																																
Employer matching contributions as a percent of pay:	____%	____%																														
Actual dollar amount of employer matching contribution:	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
4. Employer-provided transportation subsidy or company car																																
If car was provided, please specify % of personal use	____%	____%																														
5. Employer-provided club dues, memberships																																
Indicate whether figure is yearly, monthly, weekly, hourly, etc.																																
6. Housing allowance (Non-military) (Military allowances should be included on previous page.)																																
Indicate whether figure is yearly, monthly, weekly, hourly, etc.																																
Was the allowance permanent or temporary?	☐ Permanent	☐ Temporary																														
If temporary, when did it end?																																
7. Other employer-provided benefit (please describe)																																
_____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
Indicate whether figure is yearly, monthly, weekly, hourly, etc.																																
8. Other employer-provided benefit (please describe)																																
_____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>															
Indicate whether figure is yearly, monthly, weekly, hourly, etc.																																



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation**

Victim's SSN or Nat'l ID #:

			-			-				
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Part II. h - Collateral Source Compensation

Social Security and Worker's Compensation Programs - Please identify and describe any payments that the Victim has received, is receiving or has applied to receive from the Social Security Administration or from worker's compensation programs as a result of the Victim's injury. (Include uniformed service benefits similar to Social Security or worker's compensation.) Attach any pending applications and determinations.

Other Payments - Please identify and describe any other payments, including medical payments, that the Victim received as compensation for or in response to the injury (excluding charitable contributions).

☐ Note: if you need more space to answer Part II.h, check the box and continue on another copy of this page



September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part II - Compensation

Victim's SSN or Nat'l ID #:

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Part II. i - Other Information (optional)

Please use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individualized circumstances of your claim and the calculation of the economic and non-economic loss as well as collateral offsets. You may also attach any additional documents not already requested that you believe might be relevant.

☐ Check here if you need more space to answer Part II.i and are attaching additional pages.

Supporting Documentation - Please see the Supporting Documentation Checklist at the end of this form to identify the documents you need to send with your claim.



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part III - Attestations and Certifications**

Victim's SSN or Nat'l ID #:

				-			-				
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Part III. a - Privacy Act Notice

The 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, 115 Stat.230 ("Air Transportation Safety and System Stabilization Act"). 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.

Part III. b - Certification of Dismissal of any Legal Action

Have you or any dependent, spouse, or beneficiary of the Victim filed a civil action (or been a party to an action) 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 (other than civil actions to recover collateral source obligations or a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit any terrorist act)?

Yes ☐ No ☐ If Yes, has such action been dismissed as of March 21, 2002? Yes ☐ No ☐

Initial here _____

(please attach proof of dismissal if applicable)

Part III. c - Acknowledgement of Waiver of Rights

I hereby acknowledge that by submission of a substantially complete Personal Injury Compensation Form I am **waiving** the right to file a civil action (or be a party to an action) in any Federal or State court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001.

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

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Signature of Claimant

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Date (mm/dd/yyyy)



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part III - Attestations and Certifications**

Victim's SSN or Nat'l ID #:

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Part III. d - Authorization for 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 (Compensation Fund) from individuals, employers, hospitals, medical service providers, other federal, state or local agencies including the Social Security Administration and the Internal Revenue Service, or other sources having information relating to my claim. This information may include, but is not limited to, medical, employment, and financial information about me or the victim whom I represent.

I Further Authorize the U.S. Department of Justice to disclose any records or information relating to my Compensation Fund claim to: agency contractors assisting in the administration of the Compensation Fund; other federal, state, or local agencies, including the Department of the Treasury; 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 my name as the claimant filing a claim and the name of the Victim 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 having information pertinent to my claim to release such information to a duly accredited representative of the Department of Justice during the review of my claim to the 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. This authorization is valid for five (5) years from the date signed or upon my written termination whichever is sooner.

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

I Certify that I am the person named below (claimant to the Compensation Fund) and I authorize the release of information listed above.

Signature of Claimant

--

Signature of Claimant

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Date (mm/dd/yyyy)

Part III. e - Notarized Certification of Accuracy of Information

I hereby certify that the information provided in this application is true and accurate to the best of my knowledge. 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.

--

Signature of Claimant (Sign in the presence of Notary Public)

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Date (mm/dd/yyyy)

Official Notarization - Please have this page certified by a Notary Public (or equivalent for non-U.S. Personal Representatives). The Notary Public should apply seal to this page.

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Signature of Notary Public

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Date (mm/dd/yyyy)

Victim's SSN or National ID

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[illegible]



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part IV -- Supporting Documentation Checklist**

Victim's SSN or National ID #

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In order to process your claim, we need certain supporting documents to substantiate information you provided. This checklist has been developed to help you compile those documents. Please submit it with your claim.

Supporting Documentation for Part I (continued)	Attached ?	For Internal Use Only
Other Documentation (optional) Other documentation you have included in support of Part I: Other (please describe) _____ Other (please describe) _____ Other (please describe) _____ Other (please describe) _____	☐ ☐ ☐ ☐	
Part I.f – Advance Benefits Election (only if requesting direct deposit) Copy of voided check	☐	

Supporting Documentation for Part II (Compensation)	Attached ?	For Internal Use Only
Part II.c – Dependents Copy of 2000 Federal/National Tax Return	☐	

Victim's SSN or National ID

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Supporting Documentation for Part II (Compensation)	Attached ?	For Internal Use Only
Part II.e – Victim's Medical Loss (required) - Documentation of all claimed medical expenses not-reimbursed. - Documentation of all claimed future medical expense that will not be reimbursed. - Insurance information: Documentation of your health insurance coverage(s)	☐ ☐ ☐	_____ _____ _____
Part II.f – Victim's Loss of Earnings to date Documentation of current loss of earnings (number of days lost that were not reimbursed and related compensation lost) Number of Days _____ Affidavit from employer Pay stubs Salary letter End of year pay statement Other (please describe) _____ Other (please describe) _____	☐ ☐ ☐ ☐ ☐ ☐	_____ _____ _____ _____ _____ _____



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part IV -- Supporting Documentation Checklist**

Victim's SSN or National ID #

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Supporting Documentation for Part II (continued)

	Attached ?	For Internal Use Only
Part II.g – Victim's Loss of Future Earnings		
• Future loss of earnings (expected duration and related compensation that will be lost) Duration _____		
Bonus letter _____	☐	_____
End of year benefit statement _____	☐	_____
End of year pay statement _____	☐	_____
Other (please describe) _____	☐	_____
Other (please describe) _____	☐	_____
Other (please describe) _____	☐	_____
 Compensation Information for Disabled Claimants (base salary/wages)		
Please attach written proof of the Victim's base salary/wages for 2002, 2001, 2000, and 1999. Examples of the types of proof to include are listed below. You do not need to attach all of these documents for each year. All that is needed is a single supporting document for each year - one that you believe best substantiates the compensation information you provided in the form:		
Year-end pay statement _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	_____
Pay stubs _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	_____
Salary letter _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	_____
Other (please describe) _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	_____
Other (please describe) _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	_____
Tax information/returns (Federal/National, State, local, other) _____	☐	_____



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part IV -- Supporting Documentation Checklist**

Victim's SSN or National ID #

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Supporting Documentation for Part II (continued)

	Attached ?	For Internal Use Only
Compensation Information for Disabled Claimants (additional compensation) Please attach written proof of additional sources of compensation the Victim received in 2002, 2001, 2000, and 1999. Examples of the types of documents to include are listed below. You do not need to attach all of these documents for each year. All that is needed is a single supporting document for each year -one that you believe best substantiates the additional compensation information you provided in the form:		
End of year pay statement	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Bonus letter	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Commission letter	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Overtime stubs	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Other (please describe) _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Other (please describe) _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Other (please describe) _____	'02 '01 '00 '99 ☐ ☐ ☐ ☐	
Employer-Provided Benefits Please attach written proof of employer-provided benefits in 2001 and 2000. Examples of benefits are listed below. Please check the ones that apply and for which you have attached documentation:		
Documentation on Health Benefits	'01 '00 ☐ ☐	
Pension plan description(s)	'01 '00 ☐ ☐	
Pension plan statement(s)	'01 '00 ☐ ☐	
Employer-provided transportation	'01 '00 ☐ ☐	
401k documentation	'01 '00 ☐ ☐	
Employer-provided club dues	'01 '00 ☐ ☐	
Non-military housing allowances	'01 '00 ☐ ☐	
Other (please describe) _____	'01 '00 ☐ ☐	
Other (please describe) _____	'01 '00 ☐ ☐	
Other (please describe) _____	'01 '00 ☐ ☐	



**September 11th Victim Compensation Fund of 2001
Personal Injury Compensation Form
Part IV -- Supporting Documentation Checklist**

Victim's SSN or National ID #

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Supporting Documentation for Part II (<i>continued</i>)	Attached ?	For Internal Use Only
Part II.h -- Collateral Source Compensation (required) Please attach documentation for all collateral sources of compensation the Victim has or is entitled to receive. Examples of collateral sources of compensation are listed below. Please check the ones that apply and for which you have attached documentation. Short-term disability insurance Long-term disability insurance Worker's compensation insurance Social Security Other (please describe) _____ Other (please describe) _____	☐ ☐ ☐ ☐ ☐ ☐	_____ _____ _____ _____ _____
Part II.i -- Other Information (optional) Please list any additional documents that you have included with the Compensation Form that you believe will assist the Special Master in reviewing your claim and considering your individual circumstances in deriving a compensation award for economic and non-economic harm. _____ _____ _____	☐ ☐ ☐	_____ _____ _____

Supporting Documentation for Part III (Attestations and Certification)	Attached ?	For Internal Use Only
Part III.b -- Certification of Dismissal of Legal Action Proof of dismissal (<i>only if applicable</i>)	☐	_____

September 11th Victim Compensation Fund of 2001
Exhibit A to the Personal Injury Compensation Form
Authorization for Release of Medical Records

Instructions for Claimant – please list all doctors and medical care providers who were involved in diagnosing and treating your injury in Section 1. Please copy this page and complete if you need to list more than four health care providers. Then, please print your name and address and sign in the block in Section 2.

Section 1 – Name and telephone number for doctors and health care providers

I hereby authorize the person or carrier or other provider listed below to disclose confidential information about the claimant listed below:

Doctor/Provider _____

Doctor/Provider _____

Doctor/Provider _____

Doctor/Provider _____

Section 2 – Claimant information and signature

Victim's Last Name _____ First Name _____ Middle Name _____

Victim's Social Security Number _____ Victim's Date of Birth _____

Address _____

Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____

I understand that this authorization is voluntary, and that the information to be disclosed may be protected by law. I authorize the following entity to receive confidential information pertaining to me:

The September 11th Victim Compensation Fund of 2001

The Fund is closed.

Victim's Signature

Information to be disclosed to the Victim Compensation Fund includes application or enrollment information, eligibility information, claims records, claim status, and patient medical records.

Disclosure requested will include otherwise confidential information. If the 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.

Type of coverage to which this authorization applies (the doctor or health care provider will check all that apply)

☐ Medical ☐ Disability ☐ Pharmacy ☐ Long Term Care

☐ Other (please specify) _____