OMB 1105-0078

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

Non U.S. Zip ☐

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, 2001

Was 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)

☐ Other

Date and Time of Injury

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

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form

Part I - Eligibility and Application for Advance Benefits

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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? ☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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):

U.S. SSN ☐ Representative's Social Security or National ID Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Representative's relationship to Victim: ☐ Guardian ☐ Other explain _____

Representative's Last Name

First Name | Middle Name

Street Address Line 1

Street Address Line 2

Non U.S. Zip ☐ 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

Non U.S. Zip ☐ 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 ☐

U.S. SSN

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 #: ☐☐☐ - ☐☐ - ☐☐☐☐

Part I. f - Advance Benefits Election

Eligible injured Victims may apply for Advance Benefits of $25,000 if the physical injury required hospitalization for one week or more.

Do you wish to apply for Advance Benefits?

Yes ☐ No ☐

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

☐ **I hereby certify** that I need the Advance Benefit to alleviate financial hardship, I am a physically injured Victim or Guardian of a physically injured Victim and I have not yet received an amount in excess of the Victim's lost wages plus out-of-pocket medical expenses from other sources, such as government programs or employer-provided benefits (excluding monies received from privately funded charities).

Method of Payment of Advance Benefits

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

City | State | Zip Code

Telephone Number

U.S. SSN

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 #: ☐☐☐ - ☐☐ - ☐☐☐☐

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.

Signature of Claimant

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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 _____)

☐☐☐,☐☐☐,☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form
Part II - Compensation

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

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

1) Medical Condition - Disability

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.

2) If you had a decrease in compensation due to the injury, please describe below:

☐ 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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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 _____)

	2002	2001	2000	1999
Was the Victim self-employed? If yes, enter total yearly compensation amount here.				
If not self-employed, enter **Base Salary/Wage** information here.				
Indicate whether figure provided is a yearly, monthly, bi-weekly, weekly, or hourly figure.	_____	_____	_____	_____

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) _____				
Other Compensation (Please describe) _____				
Other Compensation (Please describe) _____				
Other Compensation (Please describe) _____				
Other Compensation (Please describe) _____				

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form
Part II - Compensation

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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		
or		
☐ Victim and One Dependent		
or		
☐ Victim and Family		

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:		
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) _____		
Indicate whether figure is yearly, monthly, weekly, hourly, etc.	_____	_____
8. **Other employer-provided benefit** (please describe) _____		
Indicate whether figure is yearly, monthly, weekly, hourly, etc.	_____	_____

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form
Part II - Compensation

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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.

Signature of Claimant

Date (mm/dd/yyyy)

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form

Part III - Attestations and Certifications

U.S. SSN

☐ Victim's SSN or Nat'l ID #: ☐☐☐ - ☐☐ - ☐☐☐☐

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 adminstration 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

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)**

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.

Signature of Notary Public

Date (mm/dd/yyyy)

OMB 1105-0078

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form

Part IV -- Supporting Documentation Checklist

U.S. SSN ☐ Victim's SSN or National ID # ☐☐☐☐☐☐☐☐☐

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 (Eligibility)	*Attached ?*	*For Internal Use Only*
Part I.b -- Victim's Circumstances on September 11, 2001 (required) Documentation showing the Victim was present at the site (for example, an affidavit from the Victim's employer, records of employment, medical records, records of Federal, State, city or local government, or other sworn statement regarding the presence of the Victim)	☐	_____
Part I.c -- Information About Victim's Physical Injury (required)		
• Documentation that you were physically injured at the site and treated by a medical professional within 24 hours of being injured or rescued, unless you were unable to realize immediately the extent of your injuries or did not have appropriate care available on September 11th and treatment was sought within 72 hours of being injured or rescued. (The Special Master has discretion to extend the time period on a case-by-case basis for rescue personnel who otherwise meet this requirement, but did not seek medical treatment within 72 hours.)		
Certified medical records (from a hospital, clinic, physician, or other licensed medical professional)	☐	_____
Other (please describe) _____	☐	_____
Other (please describe) _____	☐	_____
• Documentation of the nature and/or severity of your injury (e.g., temporary or permanent):	☐	_____
• Documentation of any disability:		
Evaluation by medical expert	☐	_____
Determination by Social Security Administration	☐	_____
Determination by private insurer	☐	_____
Determination by other government entity – Federal, State, local, other (please describe) _____	☐	_____
Other (please describe) _____	☐	_____
Other (please describe) _____	☐	_____

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form

Part IV -- Supporting Documentation Checklist

U.S. SSN ☐ Victim's SSN or National ID # ☐☐☐☐☐☐☐☐☐

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	☐	_____

September 11th Victim Compensation Fund of 2001

Personal Injury Compensation Form

Part IV -- Supporting Documentation Checklist

U.S. SSN ☐

Victim's SSN or National ID # ☐☐☐ ☐☐ ☐☐☐☐

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

U.S. SSN ☐ Victim's SSN or National ID # ☐☐☐ ☐☐ ☐☐☐☐

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

U.S. SSN ☐ Victim's SSN or National ID # ☐☐☐☐☐☐☐☐☐

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

U.S. SSN ☐ Victim's SSN or National ID # ☐☐☐☐☐☐☐☐☐

Supporting Documentation for Part II (*continued*)	*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 (***only if applicable***)	☐	_____

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 hearby 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*

U.S. SSN ☐

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
P.O. Box 18698
Washington, DC 20036-8698

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)_____