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IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT IN AND FOR MIAMI-DADE COUNTY, FLORIDA

IN RE: CHAMPLAIN TOWERS SOUTH COLLAPSE LITIGATION,

CLASS REPRESENTATION

COMPLEX BUSINESS LITIGATION DIVISION

CASE NO.: 2021-015089-CA-01
_____________________________________/

**MOTION FOR APPROVAL AND ISSUANCE OF CLAIMS FORMS**

Plaintiffs Personal Injury and Wrongful Death Subclass, hereby files this Motion for Approval and Issuance of Claims Forms, and states as follows:

1. To formulate an allocation and distribution of the settlement funds collected in this putative class action, on April 1, 2022, the Court appointed Robert L. Parks, Esq. and Retired Judge John Thornton to serve as Claims Administrators.

2. Mr. Parks was tasked with the initial responsibility of evaluating all personal injury and wrongful death claims in this litigation, including but not limited to establishing a claims protocol and review process, reviewing claims forms, supplemental materials, and meetings with families and their counsel, where appropriate, to determine awards and allocations among the wrongful death and personal injury subclass members.

3. Retired Judge John Thornton was appointed to review the initial awards/allocations proposed by Claims Administrator Parks, and to make any further recommendations, as needed.

4. The Claims Administrators have worked with Plaintiffs' appointed class counsel to prepare the attached Claims Forms – one for wrongful death claims and another for personal injury claims – calling for the information necessary for the administrators to carry out their Court-appointed duties.

5. Because it is necessary to provide the Claims Administrators this information with sufficient time for them to analyze and employ it, the Court should require that the forms be returned to the Claims Administrators by a date certain.

6. Additionally, the Court's order should also direct that all potential claimants be given notice that failure to return a claim form by the proscribed date will be deemed a waiver of the claimant's right to participate in the allocation of settlement proceeds being made by the Claims Administrators.

WHEREFORE, we respectfully move the Court for an order:

a. directing the Receiver to post the Claims Forms and the Court's order on his website and to distribute the forms and the Court's order via email to all known potential claimants;

b. notifying all potential claimants that any claimant that fails to timely submit a substantially complete claim form will forfeit that claimant's right to participate in the allocation of settlement funds by the Claims Administrators;

c. requiring that the attached claims forms be returned to the Claims Administrators via an email to bob@garaylawfirm.com and jthornton@jamsadr.com within 45 days; and

d. directing the Claims Administrators to disregard any claim not made within the proscribed 45 days, but granting them the ability to receive, at their sole discretion, supplemental information on any claim timely submitted.

Dated: April 14, 2022

Respectfully submitted,

*/s/ Ricardo M. Martínez-Cid*
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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that a true and correct copy of the foregoing was electronically filed with the clerk of Court by using the Florida Courts E-Filing Portal and furnished a copy of same to all counsel of record through the Florida Court's E-Filing Portal on this 14th day of April, 2022.

*/s/ Ricardo M. Martínez-Cid*

Aaron S. Podhurst (FBN 63606)
Ricardo M. Martínez-Cid (FBN 383988)
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*Plaintiffs' Personal Injury and Wrongful Death Track Lead Counsel*

# CHAMPLAIN TOWERS SOUTH COLLAPSE

# WRONGFUL DEATH CLAIM FORM

On June 24, 2021, the Champlain Towers South Condominium building ("CTS") collapsed. The collapse of the building resulted in the death of ninety-eight (98) individuals (the "Decedents"). The purpose of this Claim Form is to provide the Claims Administrators appointed by the Court with information that will be considered when evaluating the wrongful death claims brought as a result of the CTS collapse (the "Collapse."). To be considered for eligibility to receive a portion of certain recoveries and settlements in the litigation arising out of the Collapse, you must fully complete and timely submit this Claim Form.

## INSTRUCTIONS TO CLAIMANTS

Use this Claim Form to submit a claim for wrongful death caused by the Collapse. If the Collapse resulted in a personal injury to you, please use the "Personal Injury Claim Form." This Claim Form will address both the eligibility and compensation portions of your claim.

The wrongful death claim may be prepared by the claimant(s) independently or with the assistance of counsel. However, the decision whether to file a claim, as well as completing some portions of the Claim Form, involve consideration of legal issues for which legal advice may be of substantial benefit to you. The Claims Administrators will direct all communications on the claim to your lawyer, if applicable.

**This Claim Form must be signed by the decedent's duly-appointed Personal Representative, who is the only person with legal authority under Florida law to file a claim on behalf of the decedent's estate and his or her statutory survivors.**

Prior to submitting your Claim Form to the Claims Administrators, please review the document checklist for required documentation based on your specific circumstances. The document checklist is attached to this Claim Form as Exhibit A. The checklist is provided to assist you in gathering and submitting the documents needed to determine both the eligibility and compensation portions of your claim.

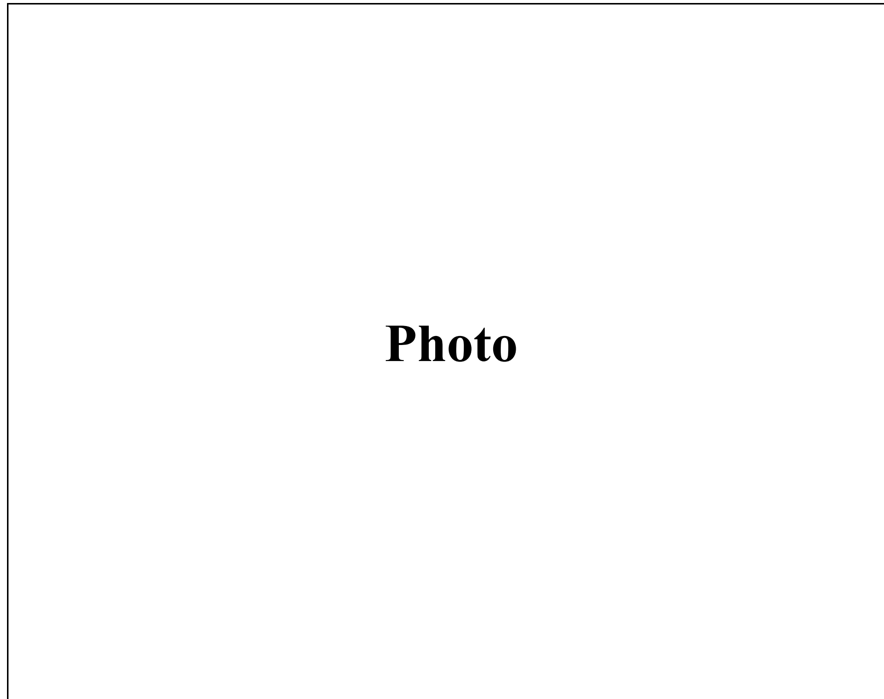
The Claims Administrators will keep all documents submitted along with the Claim Form. Please make copies for your records of any documents you submit, including your Claim Form. Each wrongful death Claim Form should pertain to only one Decedent. If a claimant/legal representative is making a claim for more than one Decedent, please fill out a separate form for each decedent.

Although this Claim Form will be maintained initially as confidential by the Claims Administrators, it may ultimately be shared with the Court and whatever other parties the Court deems appropriate, which may include other claimants, their counsel, and defendants in this litigation.

**ALL INFORMATION REQUESTED MUST BE SUBMITTED UNDER OATH AND WILL BE SUBJECT TO PENALTIES OF PERJURY**.

# [COVER PAGE]

As the Cover Page for this Claim Form, please include a photograph of the Decedent and print the Decedent's name in large type.




**ESTATE OF ____________________ [DECEDENT'S NAME]**

## SECTION 1:
## INFORMATION ABOUT THE DECEDENT'S LEGAL REPRESENTATIVE

**This Claim Form must be submitted and signed by the person with legal authority to file a claim on behalf of the Decedent, who is sometimes referred to as the personal representative of the Estate of the Decedent (the "Legal Representative"). This Section seeks information about the Legal Representative, not the Decedent. Information about the Decedent is requested in Section 2 below.**

**A "Legal Representative" is different from the lawyer who may represent the Legal Representative of the Decedent. Court approval or legal authorization to file this claim on behalf of the Decedent must be provided. (Exhibit B to this Claim Form lists examples of supporting documentation that may be submitted).**

**Full Name** (name of Legal Representative):

| | | |
|---|---|---|
| **(First)** | **(Middle)** | **(Last)** |

**Relationship to the Decedent** (check all that apply):

__ Court-Appointed Personal Representative of Decedent's Estate

__ Parent

__ Child

__ Other (please explain):

______________________________________________________________________

______________________________________________________________________

**Mailing Address:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address:**

## SECTION 2:
## LAWYER INFORMATION

**Complete this Section if the claimant(s) are represented by a lawyer. This Section does not apply if the claimant(s) have not retained a lawyer. If this Section is completed, all communication by the Claims Administrators will be directed to the lawyer.**

**Is the claimant represented by a lawyer?**
__ Yes __ No

If "yes," provide the following information:

**Lawyer Name:**

| | |
|---|---|
| (First) | (Last) |

**Law Firm Name:**

**Law Firm Address:**

Street

City/State/Zip Code

**Lawyer's Telephone:**

**Lawyer's Email Address:**

**Secondary Contact at the Lawyer's Firm:**

| | | |
|---|---|---|
| **(First)** | **(Middle)** | **(Last)** |

**Telephone:**

**Email Address:**

## SECTION 3:
## VICTIM INFORMATION - GENERAL

**"Victim Information" refers to information about the person who died as a result of the Collapse.**

**Decedent's Full Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Decedent's United States Residency**:

__ United States Citizen __ Permanent United States Resident __Other (please explain):

______________________________________________________________________

______________________________________________________________________

**Decedent's Date of Birth**:

(mm/dd/yyyy)

**Decedent's Gender:**

__ Male __ Female

**Decedent's Social Security Number/Alien Registration Number/USCIS Number:**

**Decedent's Primary Address prior to the Collapse:**

Street

City/State/Zip Code

## SPOUSE INFORMATION - GENERAL

**If the Decedent was legally married at the time of death, please provide the following information:**

**Full Name of Decedent's Spouse:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Spouse's Date of Birth:**

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Decedent's Spouse:**

**Mailing Address of Decedent's Spouse** (if different from Decedent's address)**:**

Street

City/State/Zip Code

**Date of Marriage:**

(mm/dd/yyyy)

**County/City/Country of Marriage:**

**Did Decedent's spouse die in the Collapse?"** __ Yes __ No

**If the Decedent's spouse did not die in the Collapse, and survived the Decedent, please answer the following question:**

**List all periods during which Decedent and Decedent's spouse resided separately from one another and describe the reason for the separation.**

___

___

___

## MINOR INFORMATION - GENERAL

**If the Decedent was a minor, please provide the following information**:

**FATHER**

**Full Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Parent:**

**Mailing Address of Parent** (if different from Decedent's address)**:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address of Parent:**

**MOTHER**

**Full Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Parent:**

**Mailing Address of Parent** (if different from Decedent's address)**:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address of Parent:**

## CHAMPLAIN TOWERS SOUTH – OWNER INFORMATION

**Was the Decedent an owner at any time of any unit(s) at Champlain Towers South, directly or indirectly?**

__ Yes __ No

If "yes," please provide the following information:

**Unit Number(s) of Unit(s) Owned by Decedent:**

______________________________________________________________________

**Name(s) of Unit Owner(s) for Each Unit Identified Above:**

______________________________________________________________________

______________________________________________________________________

**Date(s) when Unit was owned**

______________________________________________________________________

**Was the Decedent ever a member of the CTS Condominium Association's Board of Directors?**

__ Yes __ No

**If "yes," provide the period of time in which Decedent served on the Board, and the Decedent's title(s):**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## CHAMPLAIN TOWERS SOUTH – NON-OWNER INFORMATION

**If Decedent did not own a Unit at CTS, please provide the following information:**

**Describe the Decedent's status at CTS at the time of the Collapse**:

__ Renter/Lessee

__ Visitor

__ Other (please explain):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**If the Decedent was renting/leasing a Unit at CTS at the time of the Collapse, please provide the following information:**

**Unit Number(s):**

**Landlord Name** (for each Unit)**:**

**Date(s) of Rental Period(s)** (for each Unit):

**If the Decedent was a visitor at CTS at the time of the Collapse, please provide the following information:**

**Unit Number of the Unit Where Visit Took Place:**

**Reason for Decedent's Visit to CTS:**

**Length of Decedent's Stay** (date range(s)):

## SECTION 4:
## DECEDENT FINANCIAL INFORMATION

**The following information will be used by the Claims Administrators to determine the financial status of the Decedent at the time of his or her death. In addition to providing written responses, it is essential that documentation is provided to support the responses. This Section should only be completed if the claim includes compensation for lost income, loss of earning capacity or lost net accumulations to Decedent's Estate.**

(1) Please identify the Decedent's employer.

(2) Identify the earned income of the Decedent (that is, from his or her employment) for the five years prior to his/her death (*i.e.,* 2017, 2018, 2019, 2020, 2021 through June) and identify the source(s) of that income. [Do not include passive income such as income from investments.]

(3) Identify any income, other than earned income, received by the Decedent (*e.g.,* income from investments or rental of property) for the five years prior to his death and/or injuries and identify the source(s) of that income.

(4) State the approximate percentage of the Decedent's annual income which he or she allotted to their own needs and comforts in the two years immediately prior to death.

(5) Please provide Decedent's tax returns for the last five years.

(6) Identify any individual to whom the Decedent was contributing financial support at the time of the Collapse and the relationship that individual had to the Decedent.

(7) With regard to any individual listed in the answer to the preceding question, state the amount or amounts contributed each month to their respective support by the Decedent for the last ten years, indicating the date Decedent began such payments. Specifically, include the date of the last payment in support and the amount of said payment in support with respect to each person identified above.

(8) What is the amount of any loss of earned income from 6/24/21 to the date of submission of this Claim Form? Describe how the amount was calculated.

(9) What amount is claimed for future lost earnings and how was that amount calculated?

**To simplify the process, you can utilize the table below in conjunction with providing documentation to support the written responses.**

**Decedent's Employer(s), Job Title(s), Employer Address(es), Date(s) of Employment, and Job Description(s)** for all positions held in the ***five-year period*** preceding the Collapse (if the Decedent was self-employed, please state "Self-Employed"):

| **Most Recent Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

**Decedent's Gross Yearly Income for the Five-Year Period Preceding the Collapse:**

| **Year:** | **Gross Income:** |
|---|---|
| **2021** | |
| **2020** | |
| **2019** | |
| **2018** | |
| **2017** | |

**If the Decedent other sources of compensation, please provide information for all other compensation including but not limited to things like incentive pay, bonuses, overtime, commissions, tips, shift differentials, longevity and honoraria. For the year of the Decedent's death in 2021, indicate any compensation for the period up to the date of death.**

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

| Year: | Amount: | Nature of Compensation: |
| --- | --- | --- |
| | | |

## SECTION 5: ELIGIBILITY TO RECEIVE COMPENSATION

**The following information will be used by the Claims Administrators to determine claimants' eligibility to receive compensation under Florida law – specifically, the Florida Wrongful Death Act, Florida Statutes § 768.21.**

**Who are the Decedent's statutory survivors?** (Check all that apply)

__ Spouse [Name: __________________________ ]

__ Registered Domestic Partner [Name: __________________________ ]
[Describe date, place, and type of registration.]
__ Common-law Spouse [Name: __________________________ ]
[Describe when, where, and for how long the Claimant cohabited with the Decedent.]

__ Child (Children)
[Name, Date of Birth, and Age at Time of Collapse for each: ______________________ ]

__ Step-Child (Step-Children) [Name, Age, Date of Adoption by Decedent]

__ Mother of Minor Child [Name: __________________________ ]
__ Father of Minor Child [Name: __________________________ ]

__ Mother of Adult Child [Name: __________________________ ]
__ Father of Adult Child [Name: __________________________ ]

__ Other (please explain):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Please provide Survivor(s) information below (you should add additional pages to provide information for all survivors listed above):**

**<u>SURVIVOR #1</u>**

**Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

(mm/dd/yyyy)

**Relationship to Decedent:**

**Social Security Number/Alien Registration Number/USCIS Number:**

**Was this survivor financially supported by Decedent?**
__ Yes __ No

**If "yes" to the question above, was this individual declared as a dependent on the Decedent's tax return for the year immediately preceding the accident?**
__ Yes __ No

**SURVIVOR #2**

**Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

| |
|---|
| (mm/dd/yyyy) |

**Relationship to Decedent:**

**Social Security Number/Alien Registration Number/USCIS Number:**

**Was this survivor financially supported by Decedent?**
__ Yes __ No

**If "yes" to the question above, was this individual declared as a dependent on the Decedent's tax return for the year immediately preceding the accident?**
__ Yes __ No

**SURVIVOR #3**

**Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

| |
|---|
| (mm/dd/yyyy) |

**Relationship to Decedent:**

| |
|---|

**Social Security Number/Alien Registration Number/USCIS Number:**

| |
|---|

**Was this survivor financially supported by Decedent?**
__ Yes __ No

**If "yes" to the question above, was this individual declared as a dependent on the Decedent's tax return for the year immediately preceding the accident?**
__ Yes __ No

## SECTION 6:
## SURVIVOR INFORMATION

**The following information will allow the Claims Administrators to assess the relationship between the Survivor(s) and the Decedent for purposes of assessing damages. You should add additional pages to provide this information for each Survivor identified above:**

**SURVIVOR # 1**

**Name of Survivor: ___________________**

(1) Describe the frequency and nature of the interactions between the Survivor and the Decedent up to time of his/her death.

Answer:

(2) Does this Survivor claim damages based on mental anguish, grief or sorrow resulting from the death of the Decedent? If so, describe the character and the consequences of such loss, including:

a. a description of your physical and mental condition for the year immediately preceding Decedent's death (including any illnesses, injuries, periods of hospitalization, visits to doctors, issue of medication and drugs, and similar information); and

b. a description of your physical and mental health since the decedent's death.

Answer:

(3) Does this Survivor claim damages based on the loss of Decedent's care, guidance, advice, counsel, training, protection, society, comfort, or companionship? If so, describe the character and the consequences of such loss.

Answer:

(4) If this Survivor claims loss of the support and services of the Decedent, describe the amount of support and the nature of the services provided to you by the Decedent for each of the last two tears. Include with your submission any documents that support this claim.

Answer:

## SECTION 7: DECEDENT'S MEDICAL INFORMATION

**The following information will allow the Claims Administrators to assess the Decedent's life expectancy and help assess any claims for loss of future income in the event that he or she had not died in the Collapse.**

(1) Describe the Decedent's general state of health during the year prior to the Collapse.

Answer:

(2) Identify any physicians or medical providers who examined or treated the Decedent during the period of ten years prior to the Collapse for any *significant* health issue [*i.e.,* for health issues more serious than routine illnesses and minor injuries] and set forth the general timeframe and reasons for such examination or treatment.

Answer:

(3) Identify any hospitals, clinics or similar institutions where the Decedent had been treated or examined during the period of ten years prior to the Collapse for *any* significant health issues and set forth the general timeframe and reasons for such examination or treatment.

Answer:

(4) Did the Decedent use tobacco, alcoholic beverages or narcotics? If so, describe the extent to which he used each, specifying the particular kind of alcoholic beverage, tobacco and narcotic substance and the average quantity consumed per week.

Answer:

(5) If you are making a claim for lost income, state whether the Decedent had any physical or mental impairments that might have affected any of his or her employment or occupational opportunities over the past ten years.

Answer:

(6) Please state whether the Decedent ever filed for or obtained Social Security Disability Benefits.

Answer:

## SECTION 8: OTHER INFORMATION

**Has the Decedent's claim or the proceeds of Decedent's claim been assigned to a third party?**
__ Yes __ No

[If you answer "yes," you will be contacted by the Claims Administrators for further information.]

**Have you or the Decedent ever been involved in any other legal action, either as a plaintiff or defendant? If so, state:**

a. The date and place each such action was filed, giving the name of the court, the style and number of the case, and the names of the parties;

b. A description of the nature of each such action; and

c. The result of each such action.

Answer:

## SECTION 9:
## OTHER INFORMATION IN SUPPORT OF CLAIM

**Use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individual circumstances of your claim and the calculation of the economic and non-economic losses. You may also submit any additional documents not already requested that you believe might be relevant.**

## SIGNATURE PAGE

### HEARING REQUEST

___ I request a two (2) hour hearing before the Claims Administrators.

___ I consent to the Claims Administrators making a determination based on my Claim Form and accompanying documents and do not request a hearing. I understand I may still request a hearing if I disagree with the decision of the Claims Administrators.

### CLAIMANT CERTIFICATION

I declare under penalty of perjury that the above information is true and correct to the best of my recollection.

Date: ________________ Signature: ______________________________

Name: _________________________________

# CHAMPLAIN TOWERS SOUTH COLLAPSE

# PERSONAL INJURY CLAIM FORM

On June 24, 2021, the Champlain Towers South Condominium building ("CTS") collapsed. The collapse of the building resulted in the death of ninety-eight (98) individuals. The purpose of this Claim Form is to provide the Claims Administrators appointed by the Court with information that will be considered when evaluating the personal injury claims brought as a result of the CTS collapse (the "Collapse."). To be considered for eligibility to receive a portion of certain recoveries and settlements in the litigation arising out of the Collapse, you must fully complete and timely submit this Claim Form.

## INSTRUCTIONS TO CLAIMANTS

Use this Claim Form to submit a claim for personal injury caused by the Collapse. If the Collapse resulted in a death, please use the "Wrongful Death Claim Form." This Claim Form will address both the eligibility and compensation portions of your claim.

The personal injury claim may be prepared by the claimant(s) independently or with the assistance of counsel. However, the decision whether to file a claim, as well as completing some portions of the Claim Form, involve consideration of legal issues for which legal advice may be of substantial benefit to you. The Claims Administrators will direct all communications on the claim to your lawyer, if applicable.

Prior to submitting your Claim Form to the Claims Administrators, please review the document checklist for required documentation based on your specific circumstances. The document checklist is attached to this Claim Form as Exhibit A. The checklist is provided to assist you in gathering and submitting the documents needed to determine both the eligibility and compensation portions of your claim.

The Claims Administrators will keep all documents submitted along with the Claim Form. Please make copies for your records of any documents you submit, including your Claim Form. Each Personal Injury Claim Form should pertain to only one person. If a claim is being made for more than one individual, please fill out a separate form for each person.

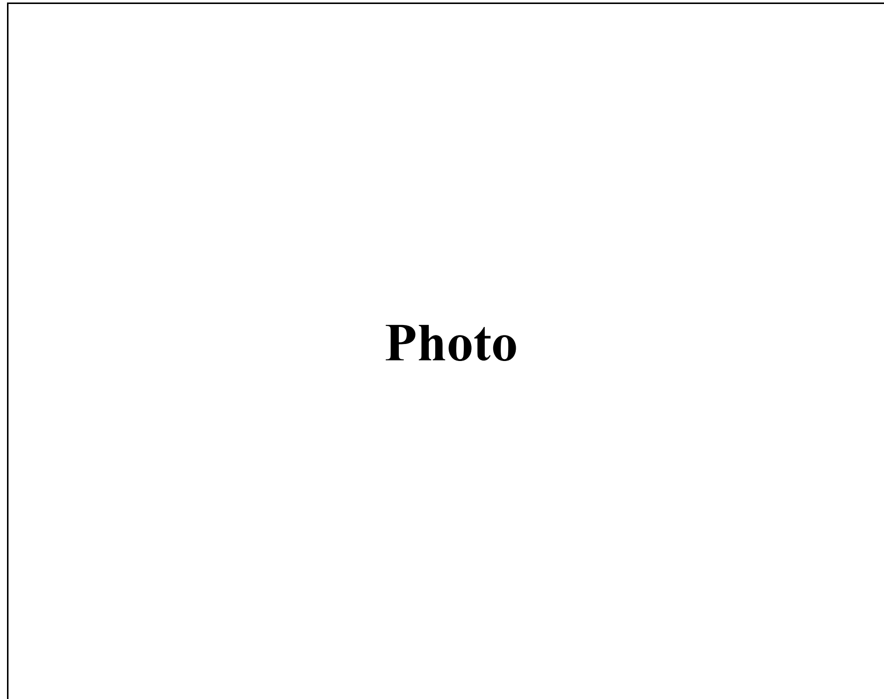
Although this Claim Form will be maintained initially as confidential by the Claims Administrators, it may ultimately be shared with the Court and whatever other parties the Court deems appropriate, which may include other claimants, their counsel, and defendants in this litigation.

**This Claim Form must be signed by the Claimant or the Claimant's legal guardian in the case of a minor.**

**ALL INFORMATION REQUESTED MUST BE SUBMITTED UNDER OATH AND WILL BE SUBJECT TO PENALTIES OF PERJURY.**

# COVER PAGE

As the Cover Page for this Claim Form, please include a photograph of the claimant and print the claimant's name in large type.



**CLAIMANT'S NAME**

## SECTION 1:
## CLAIMANT – IDENTIFICATION INFORMATION

**Full Name**:

| | | |
|---|---|---|
| | | |
| **(First)** | **(Middle)** | **(Last)** |

**Mailing Address:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address:**

**Date of Birth**:

(mm/dd/yyyy)

**Gender:** __ Male __ Female

**United States Residency Status**:

__ United States Citizen __ Permanent United States Resident __Other (please explain):

______________________________________________________________________

______________________________________________________________________

**Social Security Number/Alien Registration Number/USCIS Number:**

**Primary Address prior to the Collapse:**

Street

City/State/Zip Code

## SECTION 2:
## LAWYER INFORMATION

**Complete this Section if the claimant(s) are represented by a lawyer. This Section does not apply if the claimant(s) have not retained a lawyer. If this Section is completed, all communication by the Claims Administrators will be directed to the lawyer.**

Is the claimant represented by a lawyer?
__ Yes __ No

If "yes," please provide the following information:

**Lawyer Name:**

| | |
|---|---|
| (First) | (Last) |

**Law Firm Name:**

**Law Firm Address:**

Street

City/State/Zip Code

**Lawyer's Telephone:**

**Lawyer's Email Address:**

**Secondary Contact at the Lawyer's Firm:**

| | | |
|---|---|---|
| **(First)** | **(Middle)** | **(Last)** |

**Telephone:**

**Email Address:**

## SECTION 3:
## CLAIMANT – GENERAL INFORMATION

## SPOUSE INFORMATION

**If the Claimant was legally married at the time of the Collapse, please provide the following information:**

**Full Name of Spouse:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Spouse's Date of Birth:**

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Claimant's Spouse:**

**Mailing Address of Spouse** (if different from Claimant's address)**:**

Street

City/State/Zip Code

**Date of Marriage:**

(mm/dd/yyyy)

**County/City/Country of Marriage:**

**Did Claimant's spouse die in the Collapse?** __ Yes __ No

**If the Claimant's spouse did not die in the Collapse, please answer the following question:**

**List all periods during which Claimant and Claimant's spouse resided separately from one another and describe the reason for the separation.**

___

___

___

## MINOR INFORMATION

**If the Claimant is a minor, please provide the following information**:

**<u>FATHER</u>**

**Full Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Parent:**

**Mailing Address of Parent** (if different from Claimant's address)**:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address of Parent:**

**MOTHER**

**Full Name:**

| | | |
|---|---|---|
| (First) | (Middle) | (Last) |

**Date of Birth**:

(mm/dd/yyyy)

**Social Security Number/Alien Registration Number/USCIS Number of Parent:**

**Mailing Address of Parent** (if different from Claimant's address)**:**

Street

City/State/Zip Code

**Primary Telephone Number:**

**Email Address of Parent:**

## CHAMPLAIN TOWERS SOUTH – OWNER INFORMATION

**Was the Claimant an owner at any time of any unit(s) at Champlain Towers South, directly or indirectly?**

__ Yes __ No

If "yes," please provide the following information:

**Unit Number(s) of Unit(s) Owned by Claimant:**

______________________________________________

**Name(s) of Unit Owner(s) for Each Unit Identified Above:**

______________________________________________

______________________________________________

**Date(s) when Unit was owned**

______________________________________________

**Was the Claimant ever a member of the CTS Condominium Association's Board of Directors?**

__ Yes __ No

**If "yes," provide the period of time in which the Claimant served on the Board, and the Claimant's title(s):**

______________________________________________

______________________________________________

______________________________________________

## CHAMPLAIN TOWERS SOUTH – NON-OWNER INFORMATION

**If Claimant did not own a Unit at CTS, please provide the following information:**

**Describe the Claimant's status at CTS at the time of the Collapse**:

__ Renter/Lessee

__ Visitor

__ Other (please explain):

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**If the Claimant was renting/leasing a Unit at CTS at the time of the Collapse, please provide the following information:**

**Unit Number(s):**

**Landlord Name** (for each Unit)**:**

**Date(s) of Rental Period(s)** (for each Unit):

**If the Claimant was a visitor at CTS at the time of the Collapse, please provide the following information:**

**Unit Number of the Unit Where Visit Took Place:**

**Reason for Visit to CTS:**

**Length of Stay** (date range(s)):

## SECTION 4:
## CLAIMANT'S CIRCUMSTANCES AT THE TIME OF THE COLLAPSE

**If you are claiming a personal injury that resulted from the Collapse, please answer the following questions. The responses to these questions may be used to determine your eligibility to receive compensation.**

1) Describe your physical location on June 24, 2021, when the CTS building collapsed.

2) Provide a detailed description of your personal experience during and immediately following the Collapse.

3) State whether in the Collapse or immediately following the Collapse you were physically impacted by any object, substance or force?

4) Were you physically injured as a result of the Collapse? If so, please explain how you sustained the injuries.

5) Have you suffered any mental, emotional or psychological injuries as a result of the Collapse? If so, please describe the injuries, when they first manifested, and explain how they are related to the Collapse.

6) If you have suffered a mental, emotional or psychological injury as a result of the collapse, has that injury resulted in any physical manifestation of injury?

***If you sought medical treatment or counseling for your injuries, the details of that treatment should be disclosed in response to the questions in the next section (Section 5).***

**SECTION 5:**
**CLAIMANT'S INJURIES**

1) Describe your general state of health during the year prior to the Collapse.

Answer:

2) Describe each physical injury for which you are claiming damages in this case, specifying the part of your body that was injured, the nature of the injury, and, as to any injuries you contend are permanent, the effects on you that you claim are permanent.

Answer:

3) If you sought treatment for any physical injury, when did you first seek treatment, who did you seek treatment with, what form of treatment did you receive, and what was the diagnosis (if any)?

Answer:

4) Describe each mental, psychological or emotional injury for which you are claiming damages in this case.

Answer:

5) If you sought treatment for any mental, psychological or emotional injury, when did you first seek treatment, who did you seek treatment with, what form of treatment did you receive, and what was the diagnosis (if any)?

Answer:

6) List the names and addresses of each physician or other medical provider who has treated or examined you, and each medical facility where you have received any treatment or examination for the physical injuries for which you seek damages in this case; and state as to each the date(s) of treatment or examination and the injury or condition for which you were examined or treated.

Answer:

7) List the names and addresses of each psychiatrist, psychologist, counsellor or other mental health professional who has treated or examined you, and each facility where you have received any treatment or examination for the mental, psychological or emotional injuries for which you seek damages in this case; and state as to each the date(s) of treatment or examination and the condition for which you were examined or treated.

Answer:

8) List the names and business addresses of all other physicians, medical facilities, or other health care providers by whom or at which you have been examined or treated in the ten (10) years prior to the Collapse for any *significant* health issue [that is, for health issues more serious than routine illnesses and minor injuries]; and state as to each the dates of examination or treatment and the condition or injury for which you were examined or treated.

Answer:

9) Describe any future treatment you have scheduled and/or recommended by a physician or other medical or mental health provider, as well as an estimate of the cost of such future care.

Answer:

10) Describe what your current prognosis is for any physical injury or psychological, mental or emotional injury that you sustained and who provided you with that prognosis.

Answer:

11) Please state whether you suffered from any pre-existing physical infirmity, disability, or sickness at the time of the Collapse? If so, what was the nature of the infirmity, disability, or sickness, and describe how, if at all, the pre-existing condition has been impacted by the physical injury you sustained as a result of the Collapse.

Answer:

12) List each item of expense or damage, other than loss of income or earning capacity, that you claim to have incurred as a result of the injuries you sustained as a result of the Collapse, giving for each item the dated incurred, the name and business address to the person or entity to whom each was paid or is owed, and the goods or services for which each was incurred.

Answer:

13) Has anything been paid from any third party (*e.g.*, a health insurer, Medicaid or Medicare) for the damages listed in your answers above? If so, state the amounts paid, the name of the insurer or entity that paid the amounts, and whether any of those third parties have or claim a right of subrogation or have asserted a lien.

Answer:

## SECTION 5: CLAIMANT'S FINANCIAL INFORMATION

**If the Claimant is making a claim for lost income or future loss of earning capacity as a result of injuries sustained as a result of the Collapse, this Section should be completed. In addition to providing written responses, it is essential that documentation is provided to support the responses.**

(1) Please identify the Claimant's employer.

Answer:

(2) Identify the earned income of the Claimant (that is, from his or her employment) for the five years prior to his/her death (*i.e.,* 2017, 2018, 2019, 2020, 2021 through June) and identify the source(s) of that income. [Do not include passive income such as income from investments.]

Answer:

(3) Identify any income, other than earned income, received by the Claimant (*e.g.,* income from investments or rental of property) for the five years prior to his or her injuries and identify the source(s) of that income.

Answer:

(4) Please provide Claimant's tax returns for the last five years.

Answer:

(5) What is the amount of any loss of earned income from 6/24/21 to the date of submission of this Claim Form? Describe how the amount was calculated.

Answer:

(6) What amount is claimed for future lost earnings and how was that amount calculated?

Answer:

(7) State whether the Claimant had any physical or mental impairments that might have affected any of his or her employment or occupational opportunities over the past ten years.

Answer:

(8) Please state whether the Claimant ever filed for or obtained Social Security Disability Benefits.

Answer:

**To simplify the process, you can utilize the table below in conjunction with providing documentation to support the written responses.**

**Claimant's Employer(s), Job Title(s), Employer Address(es), Date(s) of Employment, and Job Description(s)** for all positions held in the ***five-year period*** preceding the Collapse (if the Claimant was self-employed, please state "Self-Employed"):

| **Most Recent Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

| **Previous Employer** | |
|---|---|
| **Employer Name:** | |
| **Employer Address:** | |
| **Telephone Number:** | |
| **Base Salary/Wage:** | |
| **Date Range:** | |
| **Job Title and Description:** | |

**Claimant's Gross Yearly Income for the Five-Year Period Preceding the Collapse:**

| Year: | Gross Income: |
|---|---|
| 2021 | |
| 2020 | |
| 2019 | |
| 2018 | |
| 2017 | |

**If the Claimant had other sources of compensation, please provide information for all other compensation including but not limited to things like incentive pay, bonuses, overtime, commissions, tips, shift differentials, longevity and honoraria. For the year of the Claimant's death in 2021, indicate any compensation for the period up to the date of death.**

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

| Year: | Amount: | Nature of Compensation: |
|---|---|---|
| | | |

## SECTION 6:
## OTHER INFORMATION

**Has the Claimant's claim or the proceeds of Claimant's claim been assigned to a third party?**
__ Yes __ No

[If you answer "yes," you will be contacted by the Claims Administrators for further information.]

**Have you or the Claimant ever been involved in any other legal action, either as a plaintiff or defendant? If so, state:**

a. The date and place each such action was filed, giving the name of the court, the style and number of the case, and the names of the parties;

b. A description of the nature of each such action; and

c. The result of each such action.

Answer:

## SECTION 7:
## OTHER INFORMATION IN SUPPORT OF CLAIM

**Use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individual circumstances of your claim and the calculation of the economic and non-economic losses. You may also submit any additional documents not already requested that you believe might be relevant.**

## SIGNATURE PAGE

### HEARING REQUEST

___ I request a two (2) hour hearing before the Claims Administrators.

___ I consent to the Claims Administrators making a determination based on my Claim Form and accompanying documents and do not request a hearing. I understand I may still request a hearing if I disagree with the decision of the Claims Administrators.

### CLAIMANT CERTIFICATION

I declare under penalty of perjury that the above information is true and correct to the best of my recollection.

Date: ________________ Signature: ______________________________

Name: _________________________________