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

IN RE: CHAMPLAIN TOWERS SOUTH COLLAPSE LITIGATION,

CASE NO.: 2021-015089-CA-01

_____/

CLASS REPRESENTATION

COMPLEX BUSINESS LITIGATION DIVISION

NOTICE OF FILING

Pursuant to the Court's May 11, 2012, directive to simplify the Claim Forms, we have done so in consultation with the Court-appointed Claims Administrators and hereby provide notice of filing the attached revised Claim Forms in support of Plaintiffs' Motion for Approval and Issuance of Claim Form and a Proposed Order adopting and issuing same as follows:

1. Wrongful Death Claim Form
2. Personal Injury Claim Form
3. Personal Property Claim Form
4. Proposed Order Issuing Claim Forms

Dated: May 16, 2022

Respectfully submitted,

/s/ Ricardo M. Martínez-Cid
Aaron S. Podhurst (FBN 63606)
Ricardo M. Martínez-Cid (FBN 383988)
Lea P. Bucciero (FBN 84763)
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Plaintiffs' Personal Injury and Wrongful Death Track Lead Counsel

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 16th day of May, 2022.

/s/ Ricardo M. Martínez-Cid
Aaron S. Podhurst (FBN 63606)
Ricardo M. Martínez-Cid (FBN 383988)
Lea P. Bucciero (FBN 84763)
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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 the 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 you have a claim which the law recognizes arising out the death of a loved one, as well as completing some portions of the Claim Form, involve consideration of issues for which legal advice may be of substantial benefit to you. If you require the assistance of counsel, you can contact attorney Rachel Furst (e-mail: rwf@grossmanroth.com) or attorney Curtis Miner (e-mail: curt@colson.com), who will coordinate the provision of assistance to you, through counsel selected by the Court. There will be no direct charge to you for the services of court-appointed counsel. If you are represented by an attorney you have selected, the Claims Administrators will direct all communications on the claim to the lawyer assisting you.

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.

Each wrongful death Claim Form should pertain to only one Decedent, and all persons seeking to be compensated in relation to that death should be identified in that single form. 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. Also include a recent photograph of each Claimant, the Claimant's name, and the Claimant's relationship to the Decedent.

Photos

ESTATE OF _____ [DECEDENT'S NAME]

SECTION 1:
INFORMATION ABOUT THE DECEDENT'S PERSONAL 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 "Representative"). This Section seeks information about the Representative, not the Decedent. Information about the Decedent is requested below. Proof of legal authorization to file this claim on behalf of the Decedent must be provided and attached (*e.g.*, Letters of Administration issued by a Probate Court).

Full Name (name of 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:
VICTIM INFORMATION - GENERAL

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 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)

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

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)

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)

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

Street

City/State/Zip Code

Primary Telephone Number:

Email Address of Parent:

SECTION 3:
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: _____]

__ Stepchild (Stepchildren) [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):

SURVIVOR #1

Name:

(First)	(Middle)	(Last)

Date of Birth:

(mm/dd/yyyy)

Relationship to Decedent:

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

SURVIVOR #2

Name:

(First)	(Middle)	(Last)

Date of Birth:

(mm/dd/yyyy)

Relationship to Decedent:

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

SECTION 4:
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 can either provide this information in response to the specific questions below or include the information in narrative form attached to this Claim Form:

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 general description of your physical and mental health for the year immediately preceding Decedent's death;

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

c. whether, when, and from whom the Survivor has received any grief-related health care services.

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 prior to his/her death.

Answer:

SECTION 5:
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 important that documentation is provided to support the responses. This Section should only be completed if the claim includes compensation for lost income, loss of future 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) Please provide Decedent's tax returns for the last five years.

(4) 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.

(5) 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.

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

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

(8) If the claim includes a claim for lost net accumulations of Decedent's Estate, please:

a. 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.

b. 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.

c. What amount is claimed for lost net accumulations of the Decedent's Estate 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:	
Base Salary/Wage:	
Date Range:	
Job Title and Description:	

Previous Employer	
Employer Name:	
Employer Address:	
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	

SECTION 6:
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 *significant* health issue [*i.e.,* for health issues more serious than routine illnesses and minor injuries] experienced by the Decedent.

Answer:

(3) 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 and set forth the general timeframe and reasons for such examination or treatment.

Answer:

(4) 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:

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 hearing before the Claims Administrators. (The length of the hearing will be determined by the Claims Administrator and may be up to 90 minutes.)

___ 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: _____

ATTORNEY CONTACT INFORMATION:

(contact information for attorney(s) who assisted in the preparation of this Claim Form)

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 you have a claim which the law recognizes arising out the death of a loved one, as well as completing some portions of the Claim Form, involve consideration of issues for which legal advice may be of substantial benefit to you. If you require the assistance of counsel, you can contact attorney Rachel Furst (e-mail: rwf@grossmanroth.com) or attorney Curtis Miner (e-mail: curt@colson.com), who will coordinate the provision of assistance to you, through counsel selected by the Court. There will be no direct charge to you for the services of court-appointed counsel. If you are represented by an attorney you have selected, the Claims Administrators will direct all communications on the claim to the lawyer assisting you.

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.

Photo

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):

_____

_____

Primary Address prior to the Collapse:

Street

City/State/Zip Code

SECTION 2:
CLAIMANT – GENERAL INFORMATION

SPOUSE INFORMATION

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

Is the injured Claimant's spouse joining in a claim for damages arising out the spouse's injuries (loss of consortium)? ___ Yes ___ No

Full Name of Spouse:

(First)	(Middle)	(Last)

Spouse's Date of Birth:

(mm/dd/yyyy)

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

MINOR INFORMATION

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

FATHER

Full Name:

(First)	(Middle)	(Last)

Date of Birth:

(mm/dd/yyyy)

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)

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

Street

City/State/Zip Code

Primary Telephone Number:

Email Address of Parent:

SECTION 3:
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) Describe your occupancy status at CTS on the night of the collapse (e.g., owner, renter, visitor).

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

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

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

6) 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.

7) 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 4:
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) Had you received any mental, psychological or emotional counseling or treatment before the Collapse? If so, please generally describe such counseling or treatment and include the approximate dates, therapists and medical providers for it.

Answer:

6) If you sought treatment for any mental, psychological or emotional injury for which you seek damages in this case, 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:

7) 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:

8) 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:

9) 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:

10) 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:

11) 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:

12) 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:

13) 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:

14) 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 important 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) Please provide Claimant's tax returns for the last five years.

Answer:

(4) What is the amount of any loss of earned income from the date of the Collapse (6/24/2021) to the date of submission of this Claim Form? Describe how the amount was calculated.

Answer:

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

Answer:

(6) 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:	

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

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

SECTION 6:
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 hearing before the Claims Administrators. (The length of the hearing will be determined by the Claims Administrator and may be up to 90 minutes.)

___ 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: _____

ATTORNEY CONTACT INFORMATION:

(contact information for attorney(s) who assisted in the preparation of this Claim Form)

CHAMPLAIN TOWERS SOUTH COLLAPSE
PERSONAL PROPERTY / UNIT CONTENTS 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 and the destruction of a large number of Units in the building, along with their contents. It also resulted in the destruction of personal property in the Units and in other parts of the building (*e.g.*, the garage). The purpose of this Claim Form is to provide the Claims Administrators appointed by the Court with information that will be considered when evaluating claims for damages for the loss of personal property or Unit contents 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

The personal property claim may be prepared by the claimant(s) independently or with the assistance of counsel. However, the decision whether you have a claim which the law recognizes arising out the death of a loved one, as well as completing some portions of the Claim Form, involve consideration of issues for which legal advice may be of substantial benefit to you. If you require the assistance of counsel, you can contact attorney Rachel Furst (e-mail: rwf@grossmanroth.com) or attorney Curtis Miner (e-mail: curt@colson.com), who will coordinate the provision of assistance to you, through counsel selected by the Court. There will be no direct charge to you for the services of court-appointed counsel. If you are represented by an attorney you have selected, the Claims Administrators will direct all communications on the claim to the lawyer assisting you.

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.

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

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)

SECTION 2:
PERSONAL PROPERTY / UNIT CONTENTS

List each item of personal property or Unit contents for which you are claiming damages. Please provide as much detail as practical to describe the item.

PROPERTY	**Amount**
	$
	$
Total	**$ _____**

For each item claimed, please attach, if available, the following: a photograph of the item or that includes the item in it, any receipt or other documentation reflecting its purchase or value. In the absence of documentation establishing value, please describe how value was calculated.

SECTION 4:
INSURANCE

Did you have renter or contents insurance, or any other form of insurance, that compensated you in whole or in part for any of the items of property listed above?

___ Yes ___ No

If you had such insurance, please provide the following information:

Name of the insurer(s):

Policy number(s):

Amount of your claim to the insurer: $_____

Amount paid to you by the insurer: $_____

Please also attach a copy of any claim form that you submitted to the insurer.

If the insurer has placed you on notice of a right to be reimbursed for payments made to you from any recovery you may make from someone else for the loss of your property, please attach a copy of that notice.

SECTION 5:
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 losses. You may also submit any additional documents not already requested that you believe might be relevant.

SIGNATURE PAGE

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: _____

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

COMPLEX BUSINESS LITIGATION DIVISION

IN RE: CHAMPLAIN TOWERS SOUTH COLLAPSE LITIGATION.

CLASS REPRESENTATION

CASE NO. 2021-015089-CA-01

_____/

ORDER ISSUING CLAIM FORMS

THIS CAUSE came before the Court on Plaintiffs' Motion for Approval and Issuance of Claim Forms. After having heard from counsel during the May 11, 2022, Status Conference on this issue, and after having reviewed revised Claim Forms as filed on May 16, 2022, being otherwise advised in the premises, and having considered the issues, it is **ORDERED AND ADJUDGED** as follows:

Plaintiffs' Motion for Approval and Issuance of Claim Forms is **GRANTED**, and the Court directs issuance of the revised Claim Forms filed May 16, 2022, with the following directives:

a. The Court issues the attached Wrongful Death Claim Form, Personal Injury Claim Form, and Personal Property Claim Form (collectively "Claim Forms");

b. The Receiver shall post the Claim Forms and the Court's order on his website and distribute the forms and the Court's order via email to all known potential claimants;

c. The Receiver shall notify 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;

d. The completed Claim Forms must be returned to the Claims Administrators via email to bob@garaylawfirm.com and jthornton@jamsadr.com within 45 days from the date of this order; and

e. The Claims Administrators are directed to disregard any claim not made within the proscribed 45 days, but the Court grants them the ability to receive, at their sole discretion, supplemental information on any claim timely submitted.

DONE and **ORDERED** in Chambers at Miami-Dade County, Florida, on this _____ day of May, 2022.

Hon. Michael Hanzman
Circuit Court Judge