CHAMPLAIN TOWERS SOUTH COLLAPSE

WRONGFUL DEATH CLAIM FORM

The purpose of this Claim Form is to provide the Court with information that will be considered when evaluating the wrongful death claims brought because of the Champlain Towers South collapse (the "CTS Collapse"). To be eligible to receive a portion of the recoveries and settlements in the litigation arising out of the Collapse, you must timely submit this Claim Form.

IF YOU PARTICPATE IN THE CLAIMS PROCESS, ALL AWARD DETERMINATIONS AND ALLOCATIONS BY THE COURT ARE FINAL AND NOT APPEALABLE.

You may prepare this Claim Form yourself, but you do not have to do it alone. The Court has already appointed Class Counsel—court appointed lawyers—who can assist you with completing this Claim Form. If you would like their help, please email attorney Rachel Furst (e-mail: rwf@grossmanroth.com) and/or attorney Curtis Miner (e-mail: curt@colson.com), who will help in arranging an attorney to assist you. There will be no direct charge to you for the services of court-appointed counsel. No attorney is authorized to charge for assisting you in completing and processing this form without Court approval of such fees.

INSTRUCTIONS TO CLAIMANTS

Use this Claim Form to submit a claim for wrongful death caused by the Collapse. This Claim Form may only be submitted by the court-appointed Personal Representative for the Decedent's Estate, who is the only person with legal authority under Florida law to file a claim on behalf of the Decedent's estate and all who have claims relating to the death. 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 Receiver and the Court, it may ultimately be shared with other parties the Receiver or the Court deems appropriate, which may include other claimants, their counsel, and defendants in this litigation.

The information in this form must be provided under oath and will be subject to penalties for perjury.

Submit a completed claims form to the Court-appointed Receiver, Michael I. Goldberg by emailing it to CTSReceivership@akerman.com.

THE CLAIMS DEADLINE IS JULY 18, 2022

SECTION 1:
INFORMATION ABOUT THE DECEDENT'S PERSONAL REPRESENTATIVE

Full Name of Personal Representative(s):

(First)	**(Middle)**	**(Last)**

Social Security Number (if applicable):

Mailing Address:

Street

City/State/Zip Code

Primary Telephone Number:

Email Address:

Please attach a copy of the order appointing you Personal Representative of the Estate.

SECTION 2: INFORMATION ABOUT THE DECEDENT

Decedent's Full Name:

(First)	(Middle)	(Last)

Decedent's Date of Birth:

(mm/dd/yyyy)

CTS Unit Number the Decedent was Visiting or Residing in:

Decedent's Primary Address prior to the Collapse:

Street

City/State/Zip Code

SECTION 3:
OPTIONAL ELECTION OF LIQUIDATED DAMAGE

This section is designed to offer you the opportunity to submit a simplified claim without the need of gathering or attaching additional information. **A Personal Representative that makes this election shall receive a one-million-dollar award ($1,000,000.00) as total compensation for any all claims that could be made from the settlements and recoveries being administered by this process.** This compensation will be shared between the Estate and all beneficiaries and survivors that have valid claims related to the death of the Decedent. If you elect this recovery, you need only fill out Sections 1 and 2 above, sign and date the certification below, and attach the order appointing you Personal Representative of the Estate. You need not fill out the remainder of this form.

If you choose not to elect this liquidated damage, you must fill out the remainder of this form. Your claim will go through the claims administration process and the Court will ultimately determine the amount of damages the Estate and any potential beneficiaries and survivors shall be entitled to.

Please initial your choice of the following two options below:

1. I elect to have my claim on behalf of the Estate and any potential beneficiaries and survivors liquidated for a one-million-dollar award ($1,000,000.00) as total compensation for all claims that could be made from the settlements and recoveries being administered by this process.

________ **YES, LIQUIDATE MY CLAIM**

2. I do not elect to liquidate my claim and hereby ask the Court to determine the amount of damages the Estate and any potential beneficiaries and survivors shall be entitled to.

________ **NO, DO NOT LIQUIDATE MY CLAIM**

SECTION 4
DECEDENT'S 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 also die in the Collapse? __ Yes __ No

MINOR DECEDENT INFORMATION - GENERAL

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

FATHER

Full Name:

(First)	(Middle)	(Last)

Date of Birth: ____________________

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: ____________________

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

Street

City/State/Zip Code

Primary Telephone Number: ________________________

Email Address of Parent: ________________________________

SECTION 5: ELIGIBILITY TO RECEIVE COMPENSATION

The following information will be used by the Court to determine Claimants' eligibility to receive compensation.

Is the Decedent survived by:

Spouse: ____ Yes ____ No

Parent(s): ____ Yes ____ No

Minor Child(ren): ____ Yes ____ No

Adult Child(ren): ____ Yes ____ No

Other relatives making a claim: ____ Yes ____ No

If you answered yes, please list the other relatives making a claim, and their relationship to the decedent on the lines below.

____

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____

Please provide information for the first survivor listed above. Fill out a copy of the following page for each additional survivor. In other, you will submit one page for each of survivors listed above.

SURVIVOR #1

Name:

(First)	(Middle)	(Last)

Date of Birth:

(mm/dd/yyyy)

Relationship to Decedent:

Social Security Number (if applicable):

Was this survivor financially supported by Decedent?

__ Yes __ No

SURVIVOR # [ ]

Name:

(First)	(Middle)	(Last)

Date of Birth:

(mm/dd/yyyy)

Relationship to Decedent:

Social Security Number (if applicable):

Was this survivor financially supported by Decedent?

__ Yes __ No

SECTION 4:
SURVIVOR INFORMATION

The following information will allow the Court 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. If you are providing answers on this Section 4, please provide a completed Section 4 for each Survivor:

SURVIVOR # [ ]

Name of Survivor: ___________________

(1) Describe this Survivor's relationship with the Decedent, including how often the Survivor interacted with the Decedent.

Answer:

(2) Describe how the loss of the Decedent has impacted this Survivor's life. You should include any mental anguish, grief or sorrow the Survivor suffered from the death of the Decedent and any loss of Decedent's care, guidance, advice, counsel, training, protection, society, comfort, or companionship. Feel free to include a description of any grief-related health care services the Survivor has received to help deal with the loss of the Decedent.

Answer:

(3) 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:

(Please remember to fill out a copy of this Section 4 for each Survivor unless this information is included in an attached narrative.)

SECTION 5:
DECEDENT FINANCIAL INFORMATION

The following information will be used by the Court to determine the financial losses associated with the Decedent's death. This Section should only be completed if the survivors are making a claim for lost income, loss of future earning capacity, or lost net accumulations to Decedent's Estate. 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. In either case, in addition to providing written responses, it is important that documentation be provided to support the responses.

(1) Please identify the Decedent's employers and job titles for the last five years and briefly describe their current employment status at the time of the collapse.

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(2) If you are claiming lost earnings, state the amount claimed and describe how that amount was calculated:

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(3) If you are claiming net accumulations, state the amount claimed and describe how that amount was calculated:

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(4) Please provide the Decedent's tax returns (or reasonable equivalents) for the last three to five years. If tax returns are unavailable, please submit some proof of earnings for the last three to five years.

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 Court.

___ I consent to the Court making a determination based on my Claim Form and accompanying documents and do not request a hearing.

I UNDERSTAND THAT ALL AWARD DETERMINATIONS AND ALLOCATIONS BY THE COURT IN THIS CLAIMS PROCESS ARE FINAL AND NOT APPEALABLE.

CLAIMANT CERTIFICATION

I declare under penalty of perjury that the information I have provided the Court 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)