

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

CASE NO.: 2021-015089-CA-01

COMPLEX BUSINESS
LITIGATION DIVISION

NOTICE OF FILING REVISED CLAIM FORMS

Plaintiffs hereby provide notice of filing the attached revised Claim Forms in support of
Plaintiffs' Motion for Approval and Issuance of Claim Forms:

1. Wrongful Death Claim Form
2. Personal Injury Claim Form
3. Personal Injury Simple Claim Form
4. Personal Property / Unit Contents Claim Form
5. Personal Property / Unit Contents Simple Claim Form

Dated: May 27, 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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1 SE 3rd Avenue, Suite 2300
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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 27th 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

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 PARTICIPATE 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:

<input type="text"/>	<input type="text"/>	<input type="text"/>
(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:

<input type="text"/>	<input type="text"/>	<input type="text"/>
(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.

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.

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

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

- (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.

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)

CHAMPLAIN TOWERS SOUTH COLLAPSE

PERSONAL INJURY CLAIM FORM

The purpose of this Claim Form is to provide the Court with information that will be considered when evaluating the personal injury 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 or the alternative Personal Injury Simple Claim Form.

IF YOU PARTICIPATE 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 **either** this Claim Form **or** the Personal Injury Simple 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.

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

Completed claims forms must be submitted to the Court-appointed Receiver, Michael I. Goldberg, by emailing it to: CTSReceivership@akerman.com.

[THE CLAIMS DEADLINE IS JULY 18, 2022](#)

**SECTION 1:
CLAIMANT – IDENTIFICATION INFORMATION**

Full Name:

(First)	(Middle)	(Last)

CTS Unit Number the Claimant was Visiting or Residing in:

Social Security Number (if applicable):

Mailing Address:

Street

City/State/Zip Code

Primary Telephone Number:

Email Address:

Date of Birth:

(mm/dd/yyyy)

**SECTION 2:
CLAIMANT – GENERAL INFORMATION**

SPOUSE INFORMATION

If the Claimant is married, please answer: Is the injured Claimant's spouse making a claim for loss of companionship and fellowship due to Claimant's injuries (loss of consortium)?

___ Yes ___ No

If the answer is no, you may skip the remainder of this section. If yes, please continue:

Full Name of Spouse:

(First)	(Middle)	(Last)

Social Security Number (if applicable):

--

Date of Marriage:

--

(mm/dd/yyyy)

Describe the nature of the claim:

MINOR INFORMATION

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

FATHER

Full Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>
(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:

<input type="text"/>	<input type="text"/>	<input type="text"/>
(First)	(Middle)	(Last)

Date of Birth:

<input type="text"/>
(mm/dd/yyyy)

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

<input type="text"/>

Street

<input type="text"/>

City/State/Zip Code

Primary Telephone Number:

<input type="text"/>

Email Address of Parent:

<input type="text"/>

**SECTION 4:
CLAIMANT'S INJURIES**

The following information will allow the Court to assess your 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. In either case, in addition to providing written responses, it is important that documentation such as medical records be provided to support the responses.

- 1) Describe any 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 the injury's effects on you.
- 2) If you sought treatment for any physical injury, please describe it, including when you first sought treatment, who treated you, the treatment you received.
- 3) Describe any mental, psychological, or emotional injury for which you are claiming damages in this case.
- 4) If you sought treatment for any mental, psychological, or emotional injury, please describe it, including when you first sought treatment, who treated you, and the treatment you received.
- 5) 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.
- 6) 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.
- 7) 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 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. Be sure to include all healthcare costs you incurred in connection with the treatment listed above.
- 8) 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 asserted a lien or otherwise claimed a right to be repaid from your recovery.

**SECTION 5:
CLAIMANT’S FINANCIAL INFORMATION**

This Section should only be completed if the Claimant is making a claim for lost income or loss of future earning capacity that resulted from the injuries the Claimant sustained in the CTS Collapse. 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 your employers and job titles for the last five years and briefly describe your current employment status at the time of the collapse.

- (2) Please state the amount claimed for lost earnings or lost earning capacity and describe how that amount was calculated:

- (3) Please provide your tax returns (or reasonable equivalents) for the last five years. If tax returns are unavailable, please submit some proof of earnings for the last five years.

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 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 SIMPLE CLAIM FORM

INSTRUCTIONS

On June 24, 2021, the Champlain Towers (“CTS”) collapsed. The collapse resulted in many deaths, caused personal injuries and destroyed a large number of Units, along with their contents (the “CTS Collapse”).

The purpose of this *Simple Claim Form* is to provide Class Members who survived the CTS Collapse the opportunity to receive direct compensation for personal injuries (including psychological harm and emotional distress). If You complete and submit this Claim Form, you may receive **\$50,000** from the CTS Receivership Estate, in satisfaction of any and all personal injury claims you may have. [Please note that for Unit owners who were not present at CTS at the time of the CTS Collapse, this is intended to be a “per Unit” payment to owners who have suffered a personal injury. If more than one owner of the Unit makes a valid personal injury claim, the payment would need to be shared amongst the owners.]

You may contact Court-appointed Counsel (Adam Moskowitz, at adam@moskowitz-law.com, Rachel Furst, at rwf@grossmanroth.com, and/or Curtis Miner, curt@colson.com) if you have any questions **at no cost to you**. You must complete and return this Claim Form to **Receiver Michael Goldberg by July 18, 2022**, by emailing it to: CTSReceivership@akerman.com.

Instead of completing this Simple Claim Form, **you may decide to complete the full CTS Personal Injury Claim Form**, thereby **knowingly and voluntarily waving** any rights to this flat payment of \$50,000, but You will be required to: (1) present supporting evidence and testimony for your alleged Personal Injury Claim, and (2) you will have an opportunity to appear at a hearing before the Court, who will determine: (a) whether you are entitled to a claim under the laws of the State of Florida, and (b) the appropriate amount of such claim. While there is no guarantee of *any* payment through submitting to this alternate process, that payment could potentially *exceed* \$50,000, depending on the Court’s determination.

SECTION 1:

CLAIMANT INFORMATION

Full Name:

--	--	--

(First)

(Middle)

(Last)

Primary Telephone Number:

CTS Unit Number the Claimant Owned or was Visiting or Residing in at the Time of the CTS Collapse:

Was Claimant Present at the CTS property at the Time of the Collapse:

Yes: _____ No: _____

Current Mailing Address:

Email Address:

Social Security Number (if applicable):

Date of Birth:

SECTION 2:
DECLARATIONS

1. I was an owner of a CTS unit at the time of the Collapse, or I was a renter, tenant, or guest present at CTS at the time of the Collapse, and I have suffered emotional distress and/or a physical injury.

_____ **Yes**

2. Has anything been paid from any third party (e.g., a health insurer, Medicaid or Medicare) for the treatment of your emotional distress or physical injury related to the Collapse?

_____ **Yes**

_____ **No**

- (1) If you answered **Yes** to question 2 above, please state the amounts paid, the name of the insurer or entity that paid the amounts, and whether any of those third parties have asserted a lien or otherwise claimed a right to be repaid from your recovery.

SECTION 3:

CLAIMANT CERTIFICATION

I declare, **under penalty of perjury**, that the foregoing response is true and correct (for me individually, and/or as the legal guardian of the Claimant).

Date: _____

Signature: _____

Name: _____

CHAMPLAIN TOWERS SOUTH COLLAPSE
PERSONAL PROPERTY / UNIT CONTENTS CLAIM FORM

The purpose of this Claim Form is to provide the Court with information that will be considered when evaluating claims for damages for the loss of personal property or Unit contents 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 or the alternative Personal Property/Contents Simple Claim Form.

**IF YOU PARTICIPATE 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 **either** this Claim Form **or** the Personal Property/Contents Simple Claim Form to submit a claim for the loss of personal property or Unit contents caused by the Collapse.

Note that unit owners are not eligible to submit claims for the loss of personal property or contents. The previously approved Allocation Settlement Agreement included compensation to owners for such claims.

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

Completed claims forms must be submitted to the Court-appointed Receiver, Michael I. Goldberg, by emailing it to: CTSReceivership@akerman.com.

THE CLAIMS DEADLINE IS JULY 18, 2022

**SECTION 1:
CLAIMANT – IDENTIFICATION INFORMATION**

Full Name:

(First)	(Middle)	(Last)

CTS Unit Number of Property or Contents Loss:

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, including the date it was acquired and its cost at the time. The amount claimed should reflect the value of the item at the time of its loss.

PROPERTY	Amount Claimed
	\$
	\$
Total	\$ <u> </u>

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 3:
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: \$ _____

Amount of any deductible for which you were responsible: \$ _____

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.

SIGNATURE PAGE

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 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 COLLAPSE
NON-OWNER (TENANT, OCCUPANT)
PERSONAL PROPERTY/CONTENTS
SIMPLE CLAIM FORM

On June 24, 2021, the Champlain Towers South Condominium building (“CTS”) collapsed. The collapse resulted in many deaths, injuries to many survivors and destroyed a large number of Units, along with their contents (the “CTS Collapse”).

The Court has already granted Final Approval to a Settlement between the Economic Loss Class Members (i.e., Unit Owners) and the Receiver. Included in that Settlement was a resolution of any and all claims by Unit Owners for their lost contents.

The purpose of this Claim Form is to provide all Economic Loss Class Members who **were not Unit Owners** (i.e. renters, tenants, etc.), the opportunity to receive compensation, specifically for the **loss of personal property and/or Unit contents**, as a result of the collapse.

If You agree to complete this Claim Form, and can answer “Yes” **to 1**, and **2 or 3**, each **Unit** will be entitled to a direct payment of \$10,000 (for guests, short term tenants, etc.) or \$50,000 (for “primary residents”) from the CTS Receivership Estate. Multiple occupants may not file separate claims utilizing this form but must share this total compensation. The Court has already appointed **Rachel Furst (e-mail: rwf@grossmanroth.com)** and/or **Curtis Miner (e-mail: curt@colson.com)**, who can help in arranging an attorney to assist at no charge to you. You must complete and return this Form to **Receiver**

Michael Goldberg by July 18, 2022, by emailing it to:
CTSReceivership@akerman.com .

Instead of completing this Simple Claim Form, **you may decide to complete the full CTS Personal Property / Unit Contents Claim Form**, thereby **knowingly and voluntarily waving** any rights to this flat payment of \$10,000 or \$50,000, but You will be required to present supporting evidence for your alleged Property Loss Claim. The Court will evaluate Your claim and determine: (a) whether you are entitled to a claim under the laws of State of Florida, and (b) the appropriate amount of such claim. While there is no guarantee of ***any*** payment through submitting to this alternate process, that payment could potentially ***exceed*** \$10,000 or \$50,000, depending on the results of the evaluation process.

SECTION 1: CLAIMANT INFORMATION

Full Name:

--	--	--

(First)

(Middle)

(Last)

Unit Number:

Primary Telephone Number:

Current Mailing Address:

Email Address:

SECTION 2:

DECLARATIONS

1. I was residing at, and/or present at CTS on June 24, 2021 and **did not** have any ownership of the Unit.

_____ **Yes**

AND

2. The Unit was my “primary residence” at time of CTS Collapse (and thus entitled to \$50,000 for damaged personal property)

_____ **Yes**

OR

3. The Unit was not my “primary residence” at time of CTS Collapse (and thus entitled to \$10,000 for damaged personal property)

_____ **Yes**



SECTION 3:
CLAIMANT CERTIFICATION

I declare, **under penalty of perjury**, that the foregoing responses are true and correct.

Date: _____

Signature: _____

Name: _____