Fact Sheet

Agent Tyler **Attorney**: John Smith Esq. **Date 4-14-2022**

Motor Vehicle	Yes ☐ No ☐	Liability Defect	Yes ☒ No ☐	Photos included	Yes ☒ No ☐
Passenger	Yes ☐ No ☐	Medical Malpractice	Yes ☐ No ☐		
Driver	Yes ☐ No ☐	Workmens Comp	Yes ☐ No ☐	With 3rd party	Yes ☐ No ☐
Pedestrian	Yes ☐ No ☐	Led Poisoning	Yes ☐ No ☐		
Hit and Run	Yes ☐ No ☐	Other			

Client Speaks English Yes ☐ No ☒ Spanish Yes ☒ No ☐ Other

Name of Client Ramon B. Diaz **Age 82** **DOB 7-28-1939**

Address	701 50th Street, Brooklyn, NY	Apt	3
Zip Code	11220		
Cell	(347) 208-7347		
Emergency Contact	Wife - Maria N. Diaz - 347-653-4022		
Work		Email	nunysuriel900@gmail.com

Employment

Employer	Social Security Income	Duties	
Phone #		Length	17 years
Email		Salary	$ 1637 per month per week

Husband	Married 2 children 24 & 20 years old	DOB	7-28-1939	SS #	126-78-0444
Wife	Maria N. Diaz	DOB	9-23-1941	SS #	
Domestic Partner		DOB		SS #	
Mother		DOB		SS #	
Father		DOB		SS #	
Guardian					
Relationship		DOB		SS #	

Accident Information

Date of Accident	Time	Location
4-8 2022	4 PM	Sidewalk in front of 351 11th St (private house) Brooklyn, NY 11215
Facts		

On a clear, dry day, the client was with his wife Maria #347-653-4022 coming from the bank and going home. Client walking West on the South side of 11th St when he tripped and fell on upraised sidewalk in front of the above address. Client was aided by his wife Maria and they walked home. Client's wife drove him to the NYU Langone Hospital Brooklyn. He was examined, xrays taken, a fractured nose detected and then he was released. No outside doctors. Medical Insurance: Aetna Medicare PPO ID# MEBRS3QM. Client was wearing nike sneakers on DOL. Client is 5' 1'' tall and weighs 128 lbs.

Defective Condition	2 1/4" high upraised sidewalk see diagram for NOC info	Report to be obtained by:	Client	Yes ☐ No ☐
			Rapid Signup	Yes ☐ No ☐
Police Precinct			Firm	Yes ☐ No ☐
Badge #				
Other				

No Fault info

Name	Ins co
Policy	Claim #
Adj #	Telephone

1. Driver

Owner		Driver
Make of car		
Plate #	NY ☐ NJ ☐	Other
Ins Co	Code	Policy #

2. Driver

Owner		Driver
Make of car		
Plate #	NY ☐ NJ ☐	Other
Ins Co	Code	Policy #

Injury Fractured nose, abrasions to right side of face, right hand pain, right knee pain

Previous Accidents and Injuries. NONE

Ambulance to hospital Yes ☐ No ☒

Hospital		Doctor (where client is treating)	
Hospital Name	NYU Langone Hospital Brooklyn 150 55th St, Brooklyn, NY 11220 (718) 630-7000	Name	None
ER Treatment only	Yes ☒ No ☐	Address	
Admit	Yes ☐ No ☒	Telephone	
From		Contact Person	
Through			
Still Confined	Yes ☐ No ☒		
Medical Record #	1594386		

Witnesses

Witness	Wife - Maria N. Diaz - 347-653-4022
Witness	
Witness	

Property Owner

Owner 1 Flatbush Homes LLC. 70-23 75th Ave Forest Hills, NY 11356

Management Company: Daisy Property Management 385 5th Ave 12th Floor NY, NY 10016 (212) 339-5322

Superintendent on premises?	Yes ☐ No ☒	Tel:
Name	N/A	Apt:
Lead Poisoning Cases only•	How long in Apt?	Same Apt Yes ☐ No ☐

NEW YORK STATE USA
DRIVER LICENSE
NOT FOR FEDERAL PURPOSES

Mark J.F. Schroeder
Commissioner of Motor Vehicles

ID 711 227 845
Class E

DIAZ
RAMON,B
701 50 STREET
BROOKLYN, NY 11220

Sex M Height 5'-02" Eyes BRO
DOB 07/28/1939
Expires 07/28/2028
E NONE
R NONE
Issued 07/21/2020

RAMON DIAZ
EXCELSIOR

JUL 39

aetna

1199SEIU NBF
DENTAL BENEFITS ID CARD
GRP: 115330-012-00800
Issuer (80840) 9140860054
DMO

ID W2472 58861
NAME
01 RAMON DIAZ

PCD: Sheikh, Moeen

aetna

Medicare PPO

MEDICARE ADVANTAGE PLAN
1199SEIU NBF
GRP#: 467322

MEMBER SINCE 2019
RX

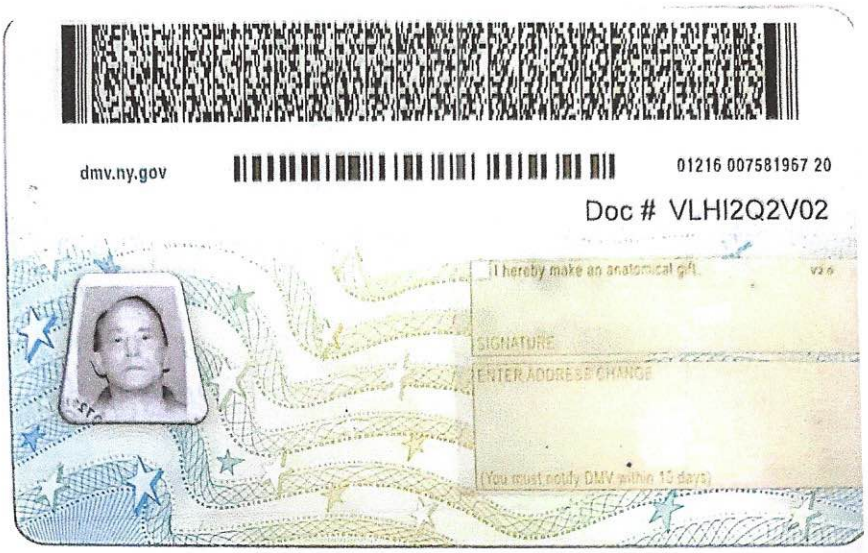
ID MEBRS3QM
NAME RAMON DIAZ
RxBIN 610502 RxPCN MEDDAET
RxGRP# RXAETD
ISSUER (80840)

MedicareRx
Prescription Drug Coverage

PCP 0 ER 75
SP 10 HO 0/A
AS 50

PRINTED ON: 06/29/2021

CMS- H5521 802



www.aetna.com
PLAN COVERAGE

PAYER NUMBER 60054 0164

PLEASE REFER TO YOUR PLAN BOOKLET
FOR BENEFIT AND COPAYMENT INFORMATION

You must choose a primary care dentist (PCD). You are responsible for specialty referral authorizations required when not referred by your PCD. Without a referral or pre-approval, you may pay more or even full price.
Note: This card does not guarantee coverage.

Aetna Life Insurance Company
PO BOX 14094
LEXINGTON KY 40512-4094

MEMBER SERVICES 1-888-905-7348

aetnaretireeplans.com

Customer Service	1-866-429-3585
Prescription Drug	1-866-429-3585
24 Hour Nurse Line	1-800-556-1555
Provider Line	1-800-624-0756
TDD/TTY	711

Send claims to:
Aetna Medicare
PO BOX 981106
EL PASO, TX 79998-1106
This card does not guarantee coverage.

Payer ID# 60054

Medicare limiting charges apply. 6022-11/18

Instructions

Read the attached information
Fracture, Nose, with X-Ray (Spanish)

Follow up with Ariel Rodriguez, MD
Why: As needed, For Follow-up after ED visit
Specialty: Medicine, Family Medicine
Contact 9000 Shore Road
Brooklyn NY 11209
718-630-8870

Schedule an appointment with Sunset Park FHC - Specialty as soon as possible for a visit
Why: for nose fracture
Specialty: Otolaryngology
Contact 150 55th Street, Room 2240
Brooklyn New York 11220-2508
718-630-7095

Today's Visit

Diagnoses

- *Fall, initial encounter*
- *Closed fracture of nasal bone, initial encounter*

Imaging Tests

CT BRAIN WITHOUT IV CONTRAST
CT CERVICAL SPINE WITHOUT IV CONTRAST
CT FACIAL BONES WITHOUT IV CONTRAST
XR CHEST
XR HAND RIGHT
XR PELVIS

Medications Given

acetaminophen (TYLENOL) Last given at 5:59 PM
tetanus-diphtheria-acellular pertussis (Tdap) vaccine (BOOSTRIX) Last given at 6:01 PM

Immunizations Given

Tdap

Blood Pressure
198/79

CLINICAL INDICATION: Trauma.

TECHNIQUE: CT of the head and face was performed without the administration of intravenous contrast. Multiplanar reconstruction was performed.

COMPARISON: None available.

FINDINGS:

CT HEAD:

No evidence of acute infarction, intracranial hemorrhage or mass lesion.

There are scattered periventricular hypodensities that likely reflect chronic ischemic microvascular changes. There is generalized cerebral atrophy with associated prominence of ventricles and sulci. There are intracranial atherosclerotic vascular calcifications.

The ventricles are normal without evidence of hydrocephalus. There are no extra-axial fluid collections.

CT FACE:

SKIN AND SUBCUTANEOUS SOFT TISSUES: No asymmetrical soft tissue swelling or hematoma.

OSSEOUS STRUCTURES: Possible bilateral nasal bone fractures with overlying soft tissue swelling. Recommend clinical correlation with point tenderness. No further fracture, dislocation or destructive lesion. Patient is edentulous.

ORBITS: The globes, retrobulbar fat, extraocular muscles, and optic nerve sheath complexes are intact and normal in morphology. There is sequela of prior bilateral cataract surgery.

PARANASAL SINUSES: Clear.

MASTOID AIR CELLS: Clear.

Electronic Signature: I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attending Amrita Arneja MD 4/8/2022 7:09 PM

IMPRESSION:

No acute intracranial hemorrhage or acute lobar infarction. Chronic ischemic microvascular disease.

Possible bilateral nasal bone fractures with overlying soft tissue swelling. Recommend clinical correlation with point tenderness. No further fracture, or dislocation.

CT CERVICAL SPINE WITHOUT IV CONTRAST

Study Result

Narrative & Impression

New York City Department of Finance

Office of the City Register

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DET IMG	2055/2203		74	ENTIRE LOT	6/18/1987	7/10/1987	DEED	2	KELLY, ANTHONY	BRETTON-GRANATOOR, GARY		✓		0
DET IMG	1545/164		74	ENTIRE LOT	8/1/1984	8/28/1984	DEED	2	MC GEE, PETER	KELLY, ANTHONY		✓		0
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DOC. DATE:	6/18/1987	**RECORDED / FILED:**	7/10/1987	**SLID #:**	N/A
DOC. AMOUNT:	$0.00	**BOROUGH:**	BROOKLYN		
% TRANSFERRED:	N/A	**RPTT #:**	13023	**MAP SEQUENCE #:**	0
MESSAGE:	N/A				

PARTY 1

NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	COUNTRY
KELLY, ANTHONY	70 EXETER ST		FOREST HILLS	NY	00000	US
KELLY, RITA	70 EXETER ST		FOREST HILLS	NY	00000	US

PARTY 2

NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	COUNTRY
BRETTON-GRANATOOR, GARY	420 12 ST		BK	NY	00000	US
BRETTON-GRANATOOR, M	420 12 ST		BK	NY	00000	US

PARTY 3/Other

NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP	COUNTRY

PARCELS

BOROUGH	BLOCK	LOT	PARTIAL	PROPERTY TYPE	EASEMENT	AIR RIGHTS	SUBTERRANEAN RIGHTS	PROPERTY ADDRESS	UNIT	REMARKS
BROOKLYN / KINGS	1017	74	ENTIRE LOT	PRE-ACRIS	N	N	N	351 11 STREET		

REFERENCES

CRFN	DOCUMENT ID	BOROUGH	YEAR	REEL	PAGE	FILE NBR

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RETAINER

The undersigned (hereinafter "Client"), residing at _____, NY _____ hereby retains you to prosecute or adjust a claim for damages arising from personal injuries sustained by me on _____, through the negligence of _____, or any other responsible persons, and the undersigned hereby further agrees not to settle this action in any manner without your written consent.

In consideration of the services rendered and to be rendered by the Firm, the Client hereby agrees to pay the Firm legal fees which shall be:

Thirty-three and one-third (33&1/3) percent of the sum recovered, whether recovered by judgment, settlement or otherwise.

The Client has been given the following options with respect to how such percentage shall be computed, and has made the selection of how the percentage shall be computed as reflected by the checking and *initialing* of the appropriate box below:

_____ Option Number One: **Client Remains Liable for Repayment of All Costs and Expenses, Regardless of the Outcome of This Matter**. Percentage is computed on the net sum recovered after deducting from the amount recovered expenses and disbursements for expert testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution of the action;

OR

R BD Option Number Two: **The Firm Agrees to Pay and Remain Liable for All Costs and Expenses, Regardless of the Outcome of This Matter**. Percentage is computed on the gross sum recovered before deducting expenses and disbursements. The Firm agrees to pay all costs and expenses of the action and the Client

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will not remain responsible for all expenses and disbursements in the event the claim or action is dismissed or otherwise rejected by any court of competent jurisdiction.

The following reflects the financial consequences of each of the above two Options, using as an example a case in which there is a recovery of $100,000 - and this number is used only as an example that is easy to understand - and the expenses and disbursements in the case are $10,000:

Option Number One Example (The Client Remains Liable for Repayment of All Costs and Expenses, Regardless of the Outcome of This Matter):

Total recovery	$100,000.00
Less expenses and disbursements:	-$10,000.00
Less 33&1/3% of remaining $90,000.00:	-$30,000.00
Client's recovery:	$60,000.00

Option Number Two Example (The Firm Agrees to Pay and Remain Liable for All Costs and Expenses, Regardless of the Outcome of This Matter):

Total recovery:	$100,000.00
Less 33&1/3% of $100,000.00	-$33,333.33
Less expenses and disbursements:	-$10,000.00
Client's recovery:	$56,666.67

The Client understands and agrees that, if the Client has selected Option Number One, the Firm reserves the right, in its sole discretion, to elect to make payment in the first instance of some or all costs, expenses and disbursements, so as not to hinder the enforcement of the claim or prosecution of the action. If the Firm has advanced these payments, the Client understands that he or she remains fully responsible to reimburse the Firm for such costs, expenses and disbursements. If the Firm elects not to make payment in the first instance of some or all costs, expenses and disbursements, the Client will advance and prepay to the Firm all such costs, expenses and disbursements as they are incurred or anticipated for the enforcement of the claim and the prosecution of the action. The Firm may, in its discretion, require the Client to deposit with the Firm a specified amount of money, as the Firm deems appropriate, in order for such costs, expenses and disbursements to be paid. Should the Client not comply with his or her financial obligations under Option Number One, the Client understands and agrees that such failure to comply shall constitute good cause for the Firm to withdraw in accordance with this agreement and the applicable rules of professional conduct.

Examples of expenses and disbursements for expert medical and other testimony and investigative or other services properly chargeable to the enforcement of the claim or prosecution

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of the action include, but are not limited to, charges for: retaining investigators; storage fees relating to the preservation of evidence; obtaining medical records; retaining expert witnesses and consultants, including locating and preparing expert witnesses and consultants, obtaining reports and testimony, and related transportation, parking, mileage, meals and hotel costs; court filing fees; service of process fees; subpoena fees; costs associated with taking depositions, including stenographer's fees videographer's fees and video teleconferencing costs; court reporter fees; notary fees; mediator, arbitrator and/or special master fees; specialized medical and legal research fees; computerized research fees; expenses for focus groups and jury consultants; photography; preparation of exhibits; photocopying and other reproduction costs; fees and expenses of non-expert witnesses; postage and delivery fees; travel costs, including parking, mileage, transportation, meals and hotel costs; long distance telephone and fax charges; and all other necessary and incidental expenses and disbursements incurred on the Client's behalf. This list is not exclusive.

In computing the fee, the costs as taxed, including interest upon a judgment, shall be deemed part of the amount recovered. For the following or similar items there shall be no deduction in computing such percentages: Liens, assignments or claims in favor of hospitals, for medical care and treatment by doctors and nurses, or self-insurers or insurance carriers.

The Client understands and agrees that, without regard to whether the Client has selected Option Number One or Option Number Two, under no circumstances will the Firm be responsible for the payment of any judgment that may be entered against the Client arising out of either the incident or the prosecution of the action, including any bill of costs.

Medical treatment and health care expenses and charges are not litigation costs and payment for same is the responsibility of the "Client" regardless of the outcome of the case.

"Client" understands that the "Attorney" will investigate the claim, and if at any time thereafter the claim does not appear to have merit, then the "Attorney" shall have the right to terminate this agreement.

If no recovery is obtained, no fee shall be payable to the "Attorney". The "Attorney", in their discretion, may withdraw at any time from the case if investigation disclosed no insurance coverage, not assets or no liability on the part of the defendant. Associate counsel may be employed at the discretion of and at the expense of the "Attorney".

This retainer agreement is not intended to cover any legal services required for taking an appeal or responding to an appeal. If legal services are required in connection with an appeal, there shall be an additional charge for said services pursuant to a separate retainer agreement between the parties.

"Client" hereby authorizes the "Attorney" to turn over all information including doctors' reports, medical records, employment records, tax records, and any and all pictures to the defense attorney and to the insurance representatives of the defendants.

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The Client hereby authorizes the Firm to endorse for the Client and deposit into the Firm's escrow account any checks which may come into the Firm's hands and which are payable to the Client as a result of the above Claim.

No promises or representation has been made by said "Attorney" as to the outcome of the claim or litigation, or as to what amounts, if any, "Client" may be entitled to recover in this case.

Dated: 4-14-2022

X Ramon B Díaz
Client's Signature

Client's Signature

Witness: _____

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No. 01LA6322832
Qualified in Bronx County
Commission Expires April 13, 2023

Power Of Attorney

To Execute HIPAA Medical Record Authorization Forms Pursuant To NY Public Health Law § 18(1)(G) As Amended 10/26/04

I, _____ of _____
(insert your name and address)

do hereby appoint: _____ with offices at _____, New York _____ my attorneys-in-fact to act (each agent may act separately) in my name, place and stead in any way which I myself could do, if I were personally present to execute HIPAA medical records authorization forms pursuant to NY Public Health Law 18(1)(g) as amended 10/26/04. This power of attorney may be revoked by me at any time. This power of attorney shall not be affected by my subsequent disability or incompetence.

To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile of this instrument may act hereunder, and that revocation or termination hereof shall be ineffective as to such third party unless and until actual notice or knowledge of such revocation or termination shall have been received by such third party, and I for myself and for my heirs, executors, legal representatives and assigns, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this instrument.

In Witness Whereof I have hereunto signed my name this 14th day of April, 2022

X Ramon B Diaz
(SIGNATURE)

ACKNOLEDGEMENT

STATE OF New York
COUNTY OF Kings
On this 14th day of April, 2022 before me the undersigned, personally appeared Ramon Diaz, personally known to be or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he executed the same in his capacity, and that by his signature on the instrument, the individual, or the person who acted on behalf of the individual, executed the instrument and that such individual made such appearance before the undersigned at Kings County, New York.

AUSTIN RYAN LANDI
Notary Public, State of New York
No. 01LA6322832
Qualified in Bronx County
Commission Expires April 13, 2023
(Notary Public)

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: (*Indicate by Initialing*)

RBD Alcohol/Drug Treatment

RBD Mental Health Information

RBD HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here RBD (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Ramon B Diaz

Signature of patient or representative authorized by law.

Date: _____

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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Qualified in Bronx County
Commission Expires April 13, 2023

The undersigned claimant therefore presents this claim for adjustment and payment. You are hereby notified that unless said claim is adjusted and paid within the time provided by law from the date of presentation to you, the claimant intends to commence an action on this claim.

Dated: New York, New York

_____,

X Ramon B Diz

VERIFICATION

STATE OF NEW YORK)
) SS.:
COUNTY OF NEW YORK)

, being duly sworn, deposes and says that deponent is the above named claimant; deponent has read the foregoing NOTICE OF CLAIM and knows its/their contents; the same is true to deponent's knowledge, except as to those matters stated to be alleged upon information and belief, and as to those matters deponent believes it to be true.

X Ramon B Diz

Sworn and subscribed to before me
on this 14 day of April, 2022

Notary Public

AUSTIN RYAN LANDI
Notary Public, State of New York
No. 01LA6322832
Qualified in Bronx County
Commission Expires April 13, 2023

INDIVIDUAL VERIFICATION

STATE OF NEW YORK)
) ss:
COUNTY OF NEW YORK)

, being duly sworn, deposes and says:

That I am the plaintiff in the action within action; that I have read the foregoing **COMPLAINT**, and knows the contents thereof; that the same is true to my own knowledge except as to the matters therein stated to be alleged upon information and belief, and as to those matters I believe it to be true.

X Ramon B Dig

Sworn to before me on
14th day of April, 2023.

Notary

AUSTIN RYAN LANDI
Notary Public, State of New York
No. 01LA6322832
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ISO ClaimSearch

REQUEST FOR DISCLOSURE TO THIRD PARTIES

(All information below must be typewritten)

NAME _____

(Last) (First) (Middle)

FORMER

NAME _____

(Last) (First) (Middle)

I certify by executing this request that I am the person named above and I understand that Federal Law provides that a person who obtains information from ClaimSearch under false pretenses may be subject to civil and/or criminal penalties. I understand that if ClaimSearch is unable to establish proper identification, it will be obliged to decline my request for disclosure.

I hereby request that ISO ClaimSearch disclose the contents of my file to the person (s) listed below:

X Ramon B Diz

_____ CLIENT'S SIGNATURE

DATE

Note to Third Parties: Please attach this form to your ISO Online Third Party Request. Please include this form with your client's signature along with additional documentation to validate the identity of your client (e.g. a copy of a government issued I.D., drivers' license, the first and last page of your retainer (signed by client & firm), power of attorney (signed by client & firm), or this form itself may be notarized). Any form that does not include proof of identity will be returned.

If you are making a request regarding a deceased individual please include the relationship of the authorizing individual below your client's representative's signature.

ATTORNEY/FIRM NAME: _____

ADDRESS: _____

EMAIL: _____

MODEL LANGUAGE

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney: Name: _____

( ) Attorney* Relationship to the Medicare Beneficiary: _____

( ) Guardian* Firm or Company Name: _____

( ) Conservator* Address: _____

( ) Power of Attorney* _____

_____

Telephone: _____

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card):

Beneficiary's Health Insurance Claim Number (number on your Medicare card):

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature: X Ramon B Dig Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____