Instructions to Claimant: Please complete the questions included in this claim form as your submission for compensation from the September 11th Victim Compensation Fund ("VCF"). This form includes both the eligibility and compensation portions of your claim.

When completing this claim form, you must:

- Print your answers using black or blue ink.
- Submit your answers in English. When filling out this form please use full legal name.
- Use either of the following to make your selection when answering a question that has a box or a circle:

  "✓" - or - "**X**"
- Submit the signed Signature Page with your completed claim form.
- Review the document checklist (Personal Injury or Deceased Claim) for required documentation based on your specific circumstances prior to mailing in your claim form. The checklist is provided to assist you in gathering and submitting the documents needed to process your claim. You do not need to send the document checklist back to the VCF.

The VCF keeps all documents you submit with your claim. Please make copies for your records of any documents you submit, including a copy of your completed claim form.

Appendices:

There are several appendices to the Hard Copy Claim Form:

Appendix A: Additional Required Information for Claims Filed for Deceased Individuals
Appendix B: Presence at the Pentagon and Shanksville, PA Sites
Appendix C: Private Physician Packet – NYC Site
Appendix D: Private Physician Packet – Pentagon & Shanksville, PA Sites

Mailing Your Form:

To submit your Hard Copy Claim Form, mail the form, appendices, and any supporting documents needed to process your claim to:

Mailing Address:
September 11th Victim Compensation Fund
P.O. Box 34500
Washington, D.C., 20043

Overnight Deliveries:
September 11th Victim Compensation Fund
Claims Processing Center
1220 L Street NW
Suite 100 - Box 408
Washington, DC 20005-4018

Please be sure all documents you submit have the victim's Social Security Number printed at the top of the page.

If you need assistance completing this form, or have any questions, **please call our toll-free Helpline at 1-855-885-1555**. For the hearing impaired, call 1-855-885-1558 (TDD). If you are calling from outside the United States, call 1-202-514-1100.

PART I – VICTIM AND CLAIMANT INFORMATION

The term "Victim" refers to the individual who has been diagnosed with a September 11th-related physical injury or condition. The term "Claimant" refers to the individual who is filing the claim to seek compensation for the victim. Individuals who are filing a Personal Injury claim on their own behalf are both the claimant and the victim.

INFORMATION ABOUT THE VICTIM

1. **Complete the information below for the individual who has been diagnosed with a 9/11-related physical injury or condition. Please use the individual's full legal name.**

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Best Telephone Number during Business Hours	Alternate Telephone Number(s)

Email Address

Date of Birth (mm/dd/yyyy)

Is the victim a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the victim's Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

Has the victim ever gone by any other names (e.g., maiden name)? ○ Yes ○ No

If **Yes**, list all former names:

Last	First	Middle

INFORMATION ABOUT THE CLAIMANT

2. In what capacity are you filing the claim on behalf of the victim? Select <u>one</u> from the list below:

- ○ **Self** – I am the victim. You do not need to complete the remaining information in this section – *skip to Question 5.*
- ○ **Personal Representative of a deceased individual.** You must also complete Claim Form Appendix A.
- ○ **Parent or Guardian of a minor.** Please provide additional information below:
  - ○ I have sole legal custody of the minor.
  - ○ I share or have joint legal custody of the minor.
- ○ **Guardian of a non-minor.**

If there is more than one Personal Representative or if you share Joint Custody of a minor, you also need to complete Question 4.

If you are an attorney who is completing this form on your client's behalf, complete the information below about the claimant and then provide your information in Question 5.

If you are the claimant and there is someone who you would like to be able to speak on your behalf or find out information about the claim (e.g., a spouse or a child), provide their contact information in Question 6.

3. Complete the following information for the claimant:

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Best Telephone Number during Business Hours	Alternate Telephone Number(s)

Email Address	
Date of Birth (mm/dd/yyyy)	

Is the claimant a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the claimant's Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

4. **If applicable, complete the following information about any co-Personal Representatives or the person with whom you share joint custody.** *Note: both signatures are required wherever the VCF asks for a signature.* **If there are more than two Personal Representatives of a deceased individual, please attach additional pages as the VCF needs the information below for all co-Personal Representatives. Please see the VCF website for additional information specific to co-Personal Representatives.**

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Date of Birth (mm/dd/yyyy)	Email Address	Telephone Number

Is the individual a U.S. citizen? ○ Yes ○ No

If **Yes**, provide the your Social Security Number or Taxpayer Identification Number:

If **No**, provide the following:

National Identification Number	Country of Citizenship	Passport Number	Passport Country

INFORMATION ABOUT THE CLAIMANT'S ATTORNEY (IF APPLICABLE)

5. **If an attorney is representing you with this claim, fill out the information below:**

Last Name	First Name	Middle Name

Law Firm Name	

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Email Address	Telephone Number

We strongly encourage all claimants who are represented by an attorney to submit their claim online. This will provide attorneys and claimants with instant access to the claim status, correspondence sent by the VCF, and the ability to upload documents directly to the claim. Visit www.vcf.gov and view our *"How to File a Claim"* page for full details on how to submit your claim online.

INFORMATION ABOUT ALTERNATIVE CONTACT (IF APPLICABLE)

6. If there is someone whom you would like to be able to speak on your behalf about your claim or to access information about your claim (e.g. a spouse or a child), list their contact information below. You do not need to list any individual whose information you have already provided.

Last Name	First Name	Middle Name

Mailing Address	Apartment/Suite Number

City	State/Province	Zip/Postal Code	Country (if not the U.S.)

Email Address	Telephone Number

PART II – ELIGIBILITY TO RECEIVE COMPENSATION

PRESENCE AT A 9/11-RELATED CRASH SITE

To be eligible for compensation from the VCF, the victim must have been present at a designated 9/11-related site from September 11, 2001 through May 30, 2002. If the victim was not present at some point during this timeframe or was not at a designated site, you are not eligible to file a claim for compensation.

7. On the list below, select the sites at which the victim was present at some point between September 11, 2001 and May 30, 2002.

☐ New York City ("NYC") Exposure Zone* – *continue to Question 8.*

*The "NYC Exposure Zone" is defined as "the area in Manhattan south of the line that runs along Canal Street from the Hudson River to the intersection of Canal Street and East Broadway, north on East Broadway to Clinton Street, and east on Clinton Street to the East River; and any area related to or along the routes of debris removal, such as barges and Fresh Kills landfill."

☐ Pentagon – *skip to Question 17 and complete Appendix B*

☐ Shanksville, PA – *skip to Question 17 and complete Appendix B*

In the questions that follow, the term "Responder" is defined as an individual who performed rescue, recovery, demolition, debris cleanup, or other related services at one of the sites in response to the September 11, 2001 terrorist attacks, regardless of whether the individual was a state or federal employee or member of the National Guard or performed the services in some other capacity. Therefore, the victim may be considered a responder even if he or she performed the listed services through a private employer or on a volunteer basis.

8. Why was the victim present in the NYC Exposure Zone during the period beginning September 11, 2001 through May 30, 2002?

☐ Part of the rescue, recovery, and debris clean-up – *continue to Question 9*.

☐ Through his or her ordinary employment as a non-responder – *continue to Question 9*.

☐ Lived in the NYC Exposure Zone – *skip to Question 15.*

☐ Other: *Specify and skip to Question 16*:

9. Select from the list below the employer or entity for which the victim worked or volunteered at the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002. If the victim worked or volunteered for more than one entity on the list, you will need to complete this section for each entity by copying these pages, completing them for each entity, and submitting them with your claim form.

☐ FDNY – specify the victim's role from the following list:

- ○ Active FDNY firefighter or fire officer
- ○ Retired FDNY officer
- ○ FDNY EMS worker
- ○ FDNY engineer, dispatcher, electrician, or other position – specify:

☐ NYPD – specify the victim's role from the following list:

- ○ Police Officer
- ○ Other – specify:

☐ Port Authority – select from the following list:

- ○ Port Authority of New York and New Jersey Police
- ○ Port Authority Trans-Hudson Corporation (PATH)
- ○ Other – specify:

☐ City of New York - select from the following list:
- ○ New York City Department of Corrections
- ○ New York City Department of Design and Construction
- ○ New York City Department of Environmental Protection
- ○ New York City Department of Sanitation
- ○ New York City Department of Transportation
- ○ New York City Morgue
- ○ New York City Transit Authority (MTA)
- ○ Office of Chief Medical Examiner
- ○ Other – specify:

☐ State of New York – select from the following list:
- ○ New York State Department of Environmental Services
- ○ New York State Police
- ○ New York State Unified Court System (includes New York City Courts)
- ○ National Guard
- ○ Other – specify:

☐ Federal Government – select from the following list:
- ○ Federal Bureau of Investigation (FBI)
- ○ FEMA
- ○ National Guard
- ○ Secret Service
- ○ U.S. Corps of Engineers
- ○ U.S. Coast Guard
- ○ U.S. Environmental Protection Agency
- ○ U.S. Marshall Service
- ○ Other – specify:

☐ Consolidated Edison
☐ Empire Blue Cross Blue Shield
☐ Lucent Technologies
☐ Red Cross
☐ Salvation Army
☐ Verizon

☐ Cleaning Company – specify:

☐ Construction Company – specify:

☐ Trucking or Transport Company – specify:

☐ Other employer or entity – provide name of company or organization:

Questions 10-14 should be answered specific to the entity you selected in Question 9.

10. Indicate below if the victim was an employee, a contractor, or a volunteer:

☐ **Employee**

Provide the employer's address, including a name and contact information for any known supervisors/points of contact:

Employer Address:

Supervisor Name:

Contact Details:

List the victim's dates of employment with this organization:

Is this employer still in business? ○ Yes ○ No ○ Do Not Know

☐ **Contractor**

Provide the employer's name and address, including contact information for any known supervisors/points of contact:

Employer Address:

Supervisor Name:

Contact Details:

List the victim's dates of employment with this organization:

Is this employer still in business? ○ Yes ○ No ○ Do Not Know

☐ **Volunteer**

11. If the victim was a member of an employee union when working or volunteering for the selected entity, or is currently a member of a union, select the union(s) from the list below:

☐ Local 1 – Plumbers and Pipefitters
☐ Local 3 – IBEW
☐ Local 6 – New York Hotel Trades Council
☐ Local 11 – District Council of Iron Workers of Northern New Jersey
☐ Local 12 or Local 12A – Asbestos Workers
☐ Local 14 and/or 14B – International Union of Operating Engineers
☐ Local 15 15A 15C 15D – International Union of Operating Engineers
☐ Local 30 – International Union of Operating Engineers
☐ Local 32BJ SEIU
☐ District Council 37 (DC-37)
☐ Local 40 and 361 – New York City Iron Workers
☐ Local 46 – Metal Lathers
☐ Local 66 – General Building Laborers
☐ Local 78, Local 79, 79 Tier B – Asbestos, Lead & Hazardous Waste Laborers; Construction and General Building Laborers'

- ☐ Local 94 94A 94B - International Union of Operating Engineers
- ☐ Local 100 – Transport Workers Union
- ☐ Local 197 – Ironworkers
- ☐ Local 237 – Teamsters
- ☐ Local 246 SEIU
- ☐ Local 282 - New York City & Long Island Teamsters
- ☐ Local 456 - Teamsters
- ☐ Local 580 - Architectural and Ornamental Iron Workers
- ☐ Local 638 – Steamfitters Construction Trades
- ☐ Local 731 – Excavators
- ☐ Local 780 - Cement Masons
- ☐ Local 825 – International Union of Operating Engineers Benefit Fund
- ☐ Local 831 – Uniformed Sanitationmen's Association and Teamsters Joint Council 16
- ☐ Local 1010 and 1018 – Pavers and Road Builders District Council Benefit Fund
- ☐ Local 1087 International Union of Painters and Allied Trades
- ☐ Local 1101 or Local 1109 – Communication Workers of America (CWA)
- ☐ 1199 SEIU – Health Care Employees
- ☐ Local 2507
- ☐ NYC District Council of Carpenters (Locals 20, 45, 157, 740, 926, 1556, 2287, 2790)
- ☐ Bricklayers Allied Craftworkers (Local 1 NY, NY Local 4)
- ☐ Other union – specify:

12. Select from the list below the location where the victim worked or volunteered for the selected entity while at the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002:

- ☐ On or adjacent to the pile/in the pit
- ☐ Staten Island/Fresh Kills Landfill
- ☐ Employer's address as provided in Question 10
- ☐ Other address within the NYC Exposure Zone – provide the cross streets if known:

13. Identify the dates (or range of dates) on which the victim worked or volunteered for the selected entity while at the NYC Exposure Zone:

14. Approximately how any hours per day was the victim present on the dates listed above?

If you have answered Questions 9-14 and did not also live in the NYC Exposure Zone, skip to Question 17.

15. Did the victim live within the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002?

○ Yes ○ No

If **Yes**, provide the address where the victim lived:

Provide the dates on which the victim physically resided in the Zone:

16. Was the victim present within the NYC Exposure Zone during the time period beginning September 11, 2001 through May 30, 2002 in a capacity other than those listed in the previous questions?

○ Yes ○ No

If **Yes**, why was the victim present in the NYC Exposure Zone?

○ Visitor ○ Other - specify:

Identify the closest location within the NYC Exposure Zone where the victim was present, including buildings and/or cross streets:

Identify the dates (or range of dates) on which the victim was present in the NYC Exposure Zone:

Approximately how any hours per day was the victim present on the dates listed above?

INFORMATION ABOUT THE VICTIM'S PRIOR CLAIM WITH THE SEPTEMBER 11TH VICTIM COMPENSATION FUND (IF APPLICABLE)

17. Did the victim file a claim with the original September 11th Victim Compensation Fund of 2001?

○ Yes ○ No

If **Yes**, did the victim receive an award from the original September 11th Victim Compensation Fund of 2001?

○ Yes ○ No ○ Do Not Know

INFORMATION ABOUT THE VICTIM'S PARTICIPATION IN LAWSUITS RELATED TO SEPTEMBER 11, 2001 (IF APPLICABLE)

18. Has the victim or any dependent, spouse or beneficiary filed a lawsuit or been a party to a lawsuit in any court for personal injury damages that resulted from the September 11, 2001 attacks (including damages related to debris removal)?

○ Yes ○ No ○ Do Not Know

If **Yes**, which lawyer or law firm(s) represented the victim in the lawsuit?

Was the lawsuit dismissed or withdrawn? ○ Yes ○ No ○ Do Not Know

If **Yes**, on what date was the lawsuit dismissed or withdrawn?

Was the lawsuit settled? ○ Yes ○ No ○ Do Not Know

If **Yes**, was it settled with all defendants or only some defendants? ○ All ○ Some

On what date was the release signed?

19. Has the victim or any dependent, spouse or beneficiary filed any other claims/lawsuits in relation to a 9/11-related physical injury or condition?

○ Yes ○ No ○ Do Not Know

If **Yes**, provide details of that lawsuit here:

INFORMATION ABOUT THE VICTIM'S 9/11-RELATED PHYSICAL INJURY OR CONDITION

To be eligible for compensation from the VCF, you must have a physical injury or condition caused by the terrorist-related aircraft crashes of September 11, 2001, or the rescue, recovery, and debris removal efforts during the immediate aftermath. You may not claim compensation for any mental health conditions. Conditions such as PTSD or anxiety are not eligible for compensation from the VCF.

If your physical injury or condition is certified for treatment by the WTC Health Program, the VCF will generally find the injury or condition eligible for compensation. If you are not being treated by the WTC Health Program, you must seek certification for your condition(s) through the WTC Health Program. In very limited circumstances, the VCF may evaluate the eligibility of the physical injury or condition through the Private Physician process.

20. Complete the table below. When providing dates, you should be as specific as possible. If you do not know the exact date, provide the month and year. *If needed, attach additional pages.*

Name of Condition	When did the victim first begin experiencing symptoms? (Provide date)	What was the victim's first date of diagnosis?	Has any federal, state, or local government agency determined that this condition is the result of 9/11-related exposure?	If Yes, what is the name of the entity (e.g. WTC Health Program, FDNY, SSA, Workers' Compensation) that determined the condition is related?	If Yes, what was the date the victim was notified?
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		
			○ Yes ○ No ○ Do Not Know		

*If your conditions are being treated by a physician **not** affiliated with the WTC Health Program, you must seek certification for the condition(s) from the WTC Health Program in order for the VCF to confirm the condition(s) is eligible for compensation. In very limited circumstances, the VCF may evaluate the eligibility of the condition through the Private Physician process. Information on the criteria for the Private Physician process can be found on the VCF website under "Forms and Resources." If you are **not** a candidate for the Private Physician process, and you submit the Private Physician forms, the information will **not** be considered by the VCF during review of your claim.*

PART III – COMPENSATION

21. What losses are you seeking for the victim's 9/11-related physical injury or condition? Select all that apply.

☐ Non-economic Loss (i.e. pain and suffering) – *If you are claiming non-economic loss only, skip to Question 28.*

☐ Replacement Services – *you must complete Questions 22 and 28-31*.

☐ Temporary Loss of Earnings – *you must complete Questions 23 and 28-31*.

☐ Permanent Loss of Earnings – *you must complete Questions 24-31*.

REPLACEMENT SERVICES

Replacement services are household services that the victim regularly provided to the household and that can no longer be performed as a result of an eligible condition. This type of loss is typically considered to be a component of loss in deceased claims, or in claims where the claimant did not have prior earned income or worked only part-time outside the home. Such services include cleaning, cooking, child care, home maintenance and repairs, and financial services.

Replacement services loss is intended to replace something that was lost – that is, something the victim used to do and now cannot do because of a 9/11-related eligible physical injury or condition.

In order to be compensated for replacement services, you must demonstrate that the victim performed the service before the onset of his or her eligible physical injury or condition (or that the victim performed the service prior to his or her death from the eligible condition), and show that the eligible injury or condition now prevents or limits the victim from performing the service.

22. If you are seeking compensation for replacement services, complete the table below:

Type of services the victim performed prior to the onset of the 9/11-related physical injury or condition:	Hours spent per week performing the services:	When did the victim stop or reduce the amount of time spent per week performing these activities?	Which 9/11-related physical injury or condition prevents the victim from performing this activity?

LOSS OF EARNINGS

Loss of earnings can be claimed for a permanent inability to work due to a 9/11-related physical disability, or for a temporary inability to work due to a 9/11-related physical injury or condition. A permanent inability to work is one that is expected to last for the rest of the victim's worklife (that is, the victim is expected never to be able to return to work), and for which a third party has made a determination of permanent disability. A temporary inability to work is one that has already resolved, or is expected to resolve before the end of the victim's worklife (that is, the victim has already returned to work, or expects to be able to return to work in the future), whether or not a third party has made a temporary disability determination.

23. If you are seeking compensation for temporary loss of earnings, provide information about the victim's employment, including the specific time periods/dates when the victim missed work and the loss of earnings/benefits associated with the time missed from work as a result of the 9/11-related physical injury or condition:

Did any government agency, insurer, or physician make a formal determination of temporary disability?

◯ Yes ◯ No ◯ Do Not Know

Name of Employer(s):	Describe the specific time periods/dates the victim missed work as a result of the 9/11-related physical injury or condition (i.e. work missed for which the victim was not and will not be compensated):	Describe the loss of earnings and/or other benefits associated with the time missed from work as a result of the victim's 9/11-related physical condition or injury:

24. If you are seeking compensation for permanent loss of earnings due to the victim's 9/11-related *physical disability, complete the following information. Otherwise, skip to Question 28.*

Is the disability a result of a 9/11 physical condition/injury? ○ Yes ○ No

Is the victim partially or totally disabled? ○ Partial ○ Total

Is the disability permanent or temporary? ○ Permanent ○ Temporary?

Has the victim submitted a disability application to any government agency or insurer, or has the victim requested a disability determination from a physician? ○ Yes ○ No ○ Do Not Know

If Yes, to what entity did the victim submit the application?

- ☐ Social Security Administration
- ☐ FDNY
- ☐ NYPD
- ☐ NYCERS
- ☐ NYSLRS
- ☐ State Workers' Compensation - identify state:
- ☐ Insurance Company - specify:
- ☐ Physician - specify:
- ☐ Other - specify:

What is the status of the application? ○ Approved ○ Denied ○ Pending ○ Do Not Know

If the victim's disability application was approved, what entity issued the determination? Identify all that apply from the list below:

- ☐ Social Security Administration
- ☐ FDNY

  Was the victim found to be disabled under the WTC Bill? ○ Yes ○ No ○ Do Not Know

  If **Yes**, was the victim re-classified under the WTC Bill? ○ Yes ○ No ○ Do Not Know
- ☐ NYPD
- ☐ NYCERS
- ☐ NYSLRS
- ☐ State Workers' Compensation - identify state:
- ☐ Insurance Company - specify:
- ☐ Physician - specify:
- ☐ Other - specify:

If you are certified by the WTC Health Program for at least one condition and do not already have a disability determination for an eligible condition from one of the standard third-party entities or sources (e.g., Social Security Administration, FDNY/NYPD, a state Workers' Compensation program, or insurance company) you may be eligible for a disability evaluation through the WTC Health Program Disability Evaluation process. This process is not for everyone. To learn more about this process and the criteria, visit "Forms and Resources" on the www.vcf.gov website.

If you are interested in seeking a disability evaluation through the WTC Health Program, check here: ☐

25. Complete the information below regarding the victim's employment and compensation history. For Personal Injury claims, provide the employment and compensation history for the three years prior to the decrease in earnings caused by the eligible condition. For Deceased claims, provide the victim's employment and compensation history for the three years prior to the victim's death and, if applicable, for the three years prior to any decrease in the victim's earnings caused by an eligible condition. If needed, attach additional pages.

Identify the victim's employer at the time the victim became disabled:

List the dates of employment for this job:

Is the victim currently working? ○ Yes ○ No

If **No**, date of last day of work:

Did the victim receive health care benefits through this employer? ○ Yes ○ No ○ Do Not Know

26. Did the victim's employer offer a Defined Benefit Pension Plan?

○ Yes ○ No ○ Do Not Know

If **Yes**, is the victim currently receiving a pension?

○ Yes ○ No ○ Do Not Know

If **Yes**, complete the table below:

Pension Amount (Dollar Amount $)	**Frequency** (Weekly, Bi-weekly, Monthly or Quarterly)	**Type of Pension** (Regular, Service or Disability)
	Please select ...	Please select ...
	Please select ...	Please select ...
	Please select ...	Please select ...
	Please select ...	Please select ...
	Please select ...	Please select ...

Did the victim's employer offer a Defined Contribution Plan, for example, a 401(k) or 403(b)?

○ Yes ○ No ○ Do Not Know

If **Yes**, was the percentage matching contribution higher than 4%? ○ Yes ○ No ○ Do Not Know

If **Yes**, please indicate the percentage: %

27. Did the victim receive any other benefits from this employer?

○ Yes ○ No ○ Do Not Know

If **Yes**, identify:

COLLATERAL SOURCE PAYMENTS

You are required to identify any compensation or benefits the victim has received, or is entitled to receive, from other sources with regards to his or her physical injury or condition as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts. Under the Air Transportation Safety and System Stabilization Act, Public Law 107-42 (2001), the Special Master is required to reduce the compensation award by the amount of collateral source compensation the victim has received, or is entitled to receive, as a result of the terrorist-related aircraft crashes of September 11, 2001 or the debris removal efforts.

28. Has the victim applied to receive any payments from the Social Security Administration or from workers' compensation programs as a result of the 9/11-related physical injury or condition? This includes uniformed service benefits similar to Social Security or workers' compensation.

○ Yes ○ No ○ Do Not Know

If **Yes**, identify the program(s) or benefit(s) applied for and the status of the application:

Program(s) / Benefit(s)	Status (Approved, Denied, or Pending)
	Please select ...
	Please select ...

29. Has the victim received, or is entitled to receive, payments from a private disability insurance carrier as a result of the 9/11-related physical injury or condition?

○ Yes ○ No ○ Do Not Know

If **Yes,** was this coverage held personally or through the victim's employer?

○ Personally Held ○ Through Employer

Is the victim currently receiving these disability payments? ○ Yes ○ No ○ Do Not Know

30. Has the victim received, or is the victim entitled to receive, any other payments as compensation as a result of the 9/11-related physical injury or condition, such as a Public Safety Officers' Benefit (PSOB) payment? You do not need to include any charitable contributions.

○ Yes ○ No ○ Do Not Know

If **Yes**, identify and describe below the payments the victim received:

31. Have the victim's dependents received or applied for any benefits from the Social Security Administration or any other government entity as a result of the victim's 9/11-related physical injury or condition?

○ Yes ○ No ○ Do Not Know

If **Yes**, identify the program and the status of the application:

Complete an **Exhibit 1 – SSA Consent Form for any dependent who is receiving benefits.*

PART IV- OTHER INFORMATION IN SUPPORT OF APPLICATION

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 loss or collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

By submitting this form, you are agreeing that you understand the notices below (continued on the following page) regarding your waiver of rights, the Privacy Act, and authorization to communicate with your attorney or other authorized representative.

Waiver of Right to file Lawsuit:

By submitting this form, you are waiving the right to file a civil action (or to be a party to any action) in any Federal or State court for damages sustained as a result of the terrorist-related aircraft crashes of September 11, 2001. For claimants filing on a victim's behalf, this waiver may apply to anyone who might seek to represent that victim in such an action. The waiver does not apply to a civil action to recover collateral source compensation, or to a civil action against any person who is a knowing participant in any conspiracy to hijack any aircraft or commit a terrorist act.

Privacy Act Notice:

By submitting this form, you are authorizing the U.S. Department of Justice to collect this information as allowed by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42 (Sept. 22, 2001), Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by Pub. Law No. 107-71, sec. 201 (Nov. 19, 2001), as amended by Public Law No. 111-347, Title II (Jan. 2, 2011), as amended by Public Law No 114-113, Title IV (Dec. 18, 2015), as amended by Pub. Law. No. 116-34 (H.R. 1327) (July 29, 2019). The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for, and the amount of, compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Department of Justice only in accordance with the provisions of the Privacy Act, and for the routine uses indicated below:

1. Where a record, either alone or in conjunction with other information, indicates a violation or potential violation of law – criminal, civil, or regulatory in nature – to the appropriate federal, state, local, territorial, tribal, or foreign law enforcement authority or other appropriate entity charged with the responsibility for investigating or prosecuting such violation or charged with enforcing or implementing such law.

2. To any person or entity that the Special Master or the Special Master's designee has reason to believe possesses information regarding a matter relating to the Victim Compensation Fund or the administration thereof, to the extent deemed to be necessary by the Special Master or her designee in order to elicit such information or cooperation from the recipient for use in the performance of an authorized activity of the Fund.

3. In an appropriate proceeding before a court, grand jury, or administrative or adjudicative body, when the Department of Justice determines that the records are arguably relevant to the proceeding; or in an appropriate proceeding before an administrative or adjudicative body when the adjudicator determines the records to be relevant to the proceeding.

4. To an actual or potential party to litigation or the party's authorized representative for the purpose of negotiation or discussion of such matters as settlement, plea bargaining, or in informal discovery proceedings.

5. To the news media and the public, when information related to a claim is at issue in another civil or criminal proceeding, unless it is determined that release of the specific information in the context of a particular case could constitute an unwarranted invasion of personal privacy.

6. To contractors, grantees, experts, consultants, students, and others performing or working on a contract, service, grant, cooperative agreement, or other assignment for the federal government, when necessary to accomplish an agency function related to the administration of the Fund.

7. To a former employee of the Department for purposes of: responding to an official inquiry by a federal, state, or local government entity or professional licensing authority, in accordance with applicable Department regulations; or facilitating communications with a former employee that may be necessary for personnel-related or other official purposes where the Department requires information and/or consultation assistance from the former employee regarding a matter within that person's former area of responsibility.

8. To a Member of Congress or staff acting upon the Member's behalf when the Member or staff requests the information on behalf of, and at the request of, the individual who is the subject of the record.

9. To the National Archives and Records Administration for purposes of records management inspections conducted under the authority of 44 U.S.C. §§ 2904 and 2906.

10. To such recipients and under such circumstances and procedures as are mandated by federal statute or treaty.

11. Records relating to an individual who was notified that a Victim Compensation Fund award was subject to rescission or recoupment, and that the paid award amount was to be returned to the United States, where the individual has not complied, may be referred to the U.S. Department of the Treasury for collection under the Treasury Offset Program, as authorized by 31 U.S.C. 3716 and other applicable law.

By this submission, you authorize the U.S. Department of Justice to disclose any records or information relating to your Victim Compensation Fund claim for the routine uses identified above and for the purpose of determining qualification and/or compensation of your claim specifically to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Communication with your Attorney or Authorized Representative:

By submitting this form, you are authorizing the Special Master, the Special Master's designees, the U.S. Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact your attorney or other persons authorized to act on your behalf (if identified in Part I. of this form) if the Special Master needs additional information or clarification about your claim.

Paperwork Reduction Act Notice:

This request is in accordance with the Paperwork Reduction Act of 1995. An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. It is estimated that respondents will complete the paper form in an average of 2 hours and the electronic form in an average of 1.5 hours.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-0092.

September 11th
Victim Compensation Fund

Signature Page

OMB No: 1105-0092

Victim's SSN or National ID Number:

Instructions: Please review the following statements and initial where indicated. Sign and date the form, and print your name at the end of the form.

For all claimants, please initial in acknowledgement of the following:

Initials

I Understand the submission of this claim authorizes the Department of Justice to collect this information under the Privacy Act and I have read and understand the Privacy Act Notice provided. Consistent with that Notice, **I Consent** to the disclosure of any records or information relating to my Victim Compensation Fund claim for the routine uses described in that Notice, and I **Further Authorize** such disclosures for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Initials

I Certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I declare under penalty of perjury that the foregoing is true and correct. **I Understand** that false statements or claims made in connection with the application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, including as provided in 18 U.S.C. § 1001, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

Initials

I Authorize the U.S. Department of Justice to obtain any information relating to my claim under the September 11th Victim Compensation Fund of 2001 (Victim Compensation Fund or VCF) for the purpose of evaluating my claim for compensation to the VCF from individuals; employers; hospitals; medical service providers; other federal, state, or local agencies; or other sources having information relating to my claim. This information may include, but is not limited to, medical, government, and financial information (including pension records, pension files, or pension information) about me or the individual whom I represent. **I Further Authorize** individuals, entities, and federal, state and local agencies including NIOSH and the WTCHP, having information pertinent to my claim, to release such information to a duly accredited representative of the U.S. Department of Justice during the review of my claim to the Victim Compensation Fund, regardless of any previous agreement to the contrary. Copies of this authorization that show my signature are as valid as the original release signed by me. I acknowledge that I have the right to revoke this Authorization at any time, except to the extent that VCF and the entities listed above have already acted based on this Authorization. I understand that the knowing and willful request for, or acquisition of, a record pertaining to an individual under false pretenses is a criminal offense subject to a $5,000 fine.

For claimants with an attorney or other authorized representative or alternative contact, please initial in acknowledgement of the following:

Initials

I Authorize the Special Master, the Special Master's designees, the United States Department of Justice or agency contractors assisting in the administration of the Victim Compensation Fund to contact my attorney or other persons authorized to act on my behalf.

For claimants filing on behalf of a deceased individual, please initial in acknowledgement of the following:

Initials

I Certify that I have provided the required Notice of Filing of Claim to all of the decedent's living relatives and potentially interested parties by either personal delivery or certified mail, return receipt requested, and that I am not aware of anyone else to whom such notice should be provided. **I also Authorize** the U.S. Department of Justice to publish my name as well as the name of the deceased individual on whose behalf I am seeking compensation.

Signature of Claimant or Authorized Representative

Date of Signature (mm/dd/yyyy)

Print Name