CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Special Needs Trust FBO Edmund J. Rotchford III — N/A
Last Name, First, Middle — Date of Birth

Box 67 Cooper Station
Street Address/Mailing Address

New York NY 10276 — 33-8669059
City, State Zip Code — Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name Trustee
FBO Edmund J. Rotchford III

Mailing Address
Box 67 Cooper Station

City, State Zip Code New York, NY 10276

Relationship to claimant: Attorney at Law (X) or
Trustee

Explain Relationship
Trustee

3. The occurrence or accident which gave rise to this claim:

A.
Date Time Multiple Dates

B. Describe the location or place of the accident or occurrence

Westfield — Various
Municipality — Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

VIOLATION OF STATE AN FEDERAL CIVIL, CRIMINAL & CONSTITUTIONAL STATUTE(S)

4. A. Claim for Damages (Check the appropriate block)

X Personal Injury X Property Damage
X Other - Explain in detail Pending Investigation

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

Pending

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No N/A

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

F. Description of damage.

FRAUD - Violation of State + Federal laws

G. Has the damage been repaired? NO

If yes, by whom, when and cost of repair.

Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Pending Investigation

B. The amount of the claim. Violation FED + State RICO Actual - Eight Hundred twelve thousand

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

County of Union
Office of the Prosecutor

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

Romankow, Theodore
John Doe's 1-21 Jane Doe's 1-21

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Pending Investigation

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
N/A		
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes ( ) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

N/A

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer _____ Address of Employer

Your Occupation _____ Date of Employment

Rate of Pay _____ Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

N/A

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

LOCATION _____ DATE _____ TIME

C. Date property was acquired.

_____

D. Cost of property.

E. Value of property at time of accident.

_____

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

Pending Investigation

11. State the names and address of all witnesses to the accident or occurrence.

Name of Witness — Address

Name of Witness — Address

N/A

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Name of Police Officer — Police Department

Name of Police Officer — Police Department

B. Copy of Police Report attached:
( ) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

NO

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

N/A

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

NO

Claimant is ~~Deceased~~ Disabled

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

N/A

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The

County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: _____ **Signature:** _____

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 3/9/12

Executor-Trustee

Claimant or person filing claim on behalf of claimant.