WGC

LIMETREE BAY SETTLEMENT
LIEN DISCLOSURE FORM

A. CLAIMANT INFORMATION

Claimant Name:	Last	First	Middle	Suffix
Claimant ID:				
Claimant Date of Birth:		**Claimant Social Security Number:**		
Reason for No Social Security Number (if applicable):	☐ Foreign citizen ☐ Individual Taxpayer Identification Number (ITIN) only ☐ Other			
Claimant Gender:	☐ Male ☐ Female			

B. THE PURPOSE OF THIS FORM

This form needs to be filled out if you responded to Question No. 15 on the Claim Form that you had physical or emotional health manifestations that resulted from exposure to the release Incidents from the Limetree Bay Refinery for which you did seek medical treatment. **If you did not see a medical professional as a result of the Incidents, please respond to Question No. 14 instead, and you do not need to fill out this Form.**

The purpose of this Lien Disclosure Form ("Form") is to **gather information for healthcare insurers who paid for medical care related to your settlement arising from the Limetree Bay litigation ("Settlement")**. This disclosure will authorize the **Healthcare Compliance Administrator ("HCA"), Wolf Global Compliance LLC**, to address certain Medical Liens as part of any potential personal injury settlement. A Medical Lien is the reimbursement amount that your healthcare insurer(s) may pursue from any settlement, judgment, or award for the amount the insurer paid for related medical care.

Using information provided on this Form (first and last name, date of birth, Social Security Number, and gender), **the HCA will affirmatively identify and resolve,** either through global lien resolution or expenditure-based lien resolution, **any Medical Liens you may have from Medicare Part A and Part B** ("Traditional Medicare").

Additionally, the HCA will identify and resolve Medical Liens you may have from any other health insurer to the extent you provide the requested information in Section D of this form.

It is important that neither you nor your attorney individually contact, report to, or respond to correspondence from any Insurer identified in this Form concerning potential Medical Liens related to your Settlement. The HCA will handle and resolve such correspondence.

Medical Liens asserted by healthcare insurers that you do not identify in this form will be your sole responsibility - the HCA will not assist with them, and no funds will be held back from your Settlement to address them.

C. MEDICARE (PART A AND PART B)

In accordance with Section B of this Form, the HCA will automatically identify and resolve, either through global lien resolution or expenditure-based lien resolution, any Medical Lien you may have from Part A and Part B ("Traditional Medicare"). **No action is required on your part.**

D. OTHER PRIVATE AND GOVERNMENT INSURERS

In accordance with Section B of this Form, the HCA will identify and resolve any Medical Liens you may have from any other health insurer **only if you indicate "Yes" and provide complete information below.**

If you do not respond, indicate "No," or provide incomplete information, the HCA will not take action on your behalf with respect to potential Medical Liens from the health insurer, and it will be solely your responsibility to resolve any such potential Medical Lien obligation that may arise in the future.

Did any health insurer pay for medical care that you sought as a result of the exposure to the release Incidents from the Limetree Bay Refinery that is the subject of your Settlement?	☐ **YES**	☐ **NO**
If you answered "Yes" above, provide the name of the health insurer, group, and plan (as shown on your insurance card) that paid for medical care that you sought as a result of the exposure to the release Incidents from the Limetree Bay Refinery that is the subject of your Settlement:		
Additional space if you are providing information for more than one health insurer, group, or plan:		

E. AUTHORIZATION FOR USE AND DISCLOSURE OF YOUR INFORMATION

This Form authorizes the disclosure of "Protected Health Information" as that term is defined in 45 C.F.R. § 160.103. Protected Health Information includes, but is not limited to, information regarding the Claimant's medical care, treatment, and medical expenses.

By signing and submitting this Form, I authorize the use and disclosure of all Protected Health Information regarding my (or the Claimant's, if signed by a Representative) medical care, treatment, physical or mental condition, and medical expenses relating to my claim to: (1) Wolf Global Compliance, LLC (229 S. Brevard Street, Ste. 300, Charlotte, North Carolina 28202) and its agents for allocation of any settlement or judgment payment and use and/or disclosure to the holders of any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type, including Medicare or any other insurer that I identified in this Form (collectively, "Lienholders") for the purpose of identifying and resolving potential liens in connection with any award that I may receive; (2) the Lienholders for disclosure to Wolf Global Compliance, LLC for the purpose of identifying and resolving any potential liens in connection with any award that I may receive. These records will be used or disclosed solely in connection with any lien resolution involving the Claimant named in Section A.

By signing below, I acknowledge and understand all of the following and authorize Wolf Global Compliance, LLC as the HCA, to act on my behalf with each of the agencies or groups disclosed in this Form that provided healthcare coverage to me for medical care that I sought as a result of the exposure to the release Incidents from the Limetree

Bay Refinery that is the subject of my Settlement:

1. I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to my lawyer. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which my written revocation is received.

2. My authorization of the disclosure of the subject Claimant's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form, Wolf Global Compliance, LLC may not resolve Medical Liens on my behalf.

3. Any Protected Health Information or other information submitted to Wolf Global Compliance, LLC may be disclosed to potential Lienholders and may be subject to re-disclosure by such person/entity and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose my information only in accordance with this Form, any contract executed pursuant to any Settlement Agreement, orders of the Court, and/or applicable law.

4. My Protected Health Information may include information relating to sexually transmitted disease ("STD"), acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"); behavioral or mental health services; treatment for alcohol and drug abuse; and treatment for sexual/physical/mental abuse.

5. Wolf Global Compliance, LLC may represent me and act on my behalf with respect to any potential recovery claim that Medicare may have.

6. I will cooperate fully with Wolf Global Compliance, LLC and their efforts to resolve Medical Liens on my behalf, including providing and/or signing any additional authorization documents required by Lienholders.

7. I specifically authorize any State Medicaid agencies identified in Section D to exchange my Protected Health Information with Wolf Global Compliance, LLC.

8. This Form is valid until three years from the date of my signature in Section I.

9. I have a right to receive and retain a copy of this Form.

10. Any photostatic copy of this Form will have the same authority as the original and may be substituted in its place.

11. I release Wolf Global Compliance, LLC from all liability arising from their efforts to resolve Medical Liens on my behalf.

F. SIGNATURE

As the Claimant, or the legal Representative of the Deceased Claimant identified in Section A of this Form, I provide the above information so that my attorneys and/or the HCA can identify and resolve any Medical Liens asserted by any Healthcare Insurers as defined above. I understand that all Medical Liens not being resolved by the HCA, including those asserted by insurers that I did not identify in this form, are my sole responsibility.

I declare under penalty of perjury that the information provided in this Form is true and accurate.

Claimant or Representative Signature (Signatures must be handwritten ("wet ink") or electronically signed through an acceptable electronic format.)			DATE	
Printed Name of Person Signing	Last	First	Middle	Suffix

G. HOW TO SUBMIT THIS FORM

Send the completed and signed version of this Form with Your Claim Form.