



**IN THE CIRCUIT COURT OF RALEIGH COUNTY, WEST VIRGINIA**

**IN RE: GAVIN LANDFILL LITIGATION**

**CIVIL ACTION NO. 16-C-8000**

**THIS DOCUMENT RELATES TO ALL CASES**

**ORDER APPROVING PLAINTIFF FACT SHEETS**

Having reviewed the parties' agreed upon Plaintiff Fact Sheets, attached as Exhibits A and B to this Order, the Court APPROVES the Plaintiff Fact Sheets. All Plaintiff Fact Sheets shall be completed, e-filed and served no later than 30 days after the Court has approved the Plaintiff Fact Sheets. *Amended Case Management Order* (Transaction ID 59289943).

It is so ORDERED.

ENTER: July 25, 2016.

/s/ Derek C. Swope  
Lead Presiding Judge  
Gavin Landfill Litigation



# EXHIBIT A

IN THE CIRCUIT COURT OF RALEIGH COUNTY, WEST VIRGINIA

IN RE: GAVIN LANDFILL LITIGATION

Civil Action No. 16-C-8000

THIS DOCUMENT APPLIES TO ALL CASES

PLAINTIFF'S FACT SHEET

**I. REPRESENTATIVE INFORMATION**

A. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. \_\_\_\_\_  
Your Name

2. \_\_\_\_\_  
Street Address

3. \_\_\_\_\_  
City, State and Zip Code

4. Name of individual you are representing:  
\_\_\_\_\_

5. In what capacity are you representing the individual:  
\_\_\_\_\_

6. If you were appointed by a court, state the:  
\_\_\_\_\_  
Court Date of Appointment

7. Your relationship to deceased or represented person:  
\_\_\_\_\_

8. If you represent a decedent/decedent's estate, state the date of death of the decedent.

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a. Was an autopsy performed?

Yes \_\_\_\_\_ No \_\_\_\_\_

b. If yes, at which facility?

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Name of Facility

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Address

**If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who was allegedly injured by exposure to coal combustion residuals (“CCRs”). Those questions using the term “You” refer to the person who was allegedly injured by exposure to CCRs. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.**

**II. PERSONAL INFORMATION**

A. Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Name or Initial: \_\_\_\_\_

B. Maiden or other names used or by which you have been known, including the dates you used each name: \_\_\_\_\_

\_\_\_\_\_

C. Address Information

1. Present Street Address:

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Street Address	City	State	Zip Code
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2. List all other addresses where you have lived for the last thirty (30) years:

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Street Address	City	State	Zip Code	Dates at address
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Street Address	City	State	Zip Code	Dates at address
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Street Address	City	State	Zip Code	Dates at address
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Street Address	City	State	Zip Code	Dates at address
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[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Employment

1.

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Name of Current or Last Employer

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Name of Current or Last Supervisor or Superior

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Current or Last Employer Address

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Current or Last Employer Telephone Number.

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Dates of Current or Last Employment

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Current or Last Occupation

2. Have you been unemployed for health reasons for 30 consecutive days or more within the last fifteen (15) years?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

If so, please state the following for each period:

a. First and last date of period of unemployment: \_\_\_\_\_

b. Reason for unemployment: \_\_\_\_\_

c. With respect to any period of unemployment identified above, identify all unemployment benefits claimed and received for that

period of unemployment: \_\_\_\_\_

\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. Social Security, Visa or Green Card Number: \_\_\_\_\_

F. Date of Birth: \_\_\_\_\_

G. Place of Birth: \_\_\_\_\_

H. Date of Death: \_\_\_\_\_

I. Cause of Death: \_\_\_\_\_

J. Are you a Citizen of the United States?

Yes \_\_\_\_\_ No \_\_\_\_\_

K. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

L. Have you ever served in any branch of the U. S. Military?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state:

1. What branch and the dates of service: \_\_\_\_\_

2. Were you discharged for any reason relating to your health, physical or mental condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state what that condition was: \_\_\_\_\_

\_\_\_\_\_

M. Have you ever been rejected from military service for any reason relating to your health, physical or mental condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, state what that condition was: \_\_\_\_\_

\_\_\_\_\_

N. Have you filed a Workers' Compensation claim within the past 15 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed;

1. Year claim was filed: \_\_\_\_\_
2. Where claim was filed: \_\_\_\_\_
3. Claim/docket number, if applicable: \_\_\_\_\_
4. Nature of disability: \_\_\_\_\_
5. Period of disability: \_\_\_\_\_
6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

O. Have you filed a Social Security disability claim within the past 15 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed:

1. Year claim was filed: \_\_\_\_\_
2. Where claim was filed: \_\_\_\_\_
3. Claim/docket number, if applicable: \_\_\_\_\_
4. Nature of disability: \_\_\_\_\_
5. Period of disability: \_\_\_\_\_
6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

P. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any physical, psychological or emotional injury?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed:

1. Year claim was filed: \_\_\_\_\_
2. Where claim was filed: \_\_\_\_\_
3. Claim/docket number, if applicable: \_\_\_\_\_
4. Nature of disability: \_\_\_\_\_
5. Period of disability: \_\_\_\_\_
6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

Q. Have you been convicted of or pled guilty to a crime involving dishonesty or false statement (e.g., perjury) in the last 10 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so:

1. What was the offense? \_\_\_\_\_
2. What was the case number? \_\_\_\_\_
3. What was the date of conviction or plea? \_\_\_\_\_
4. In what court was the conviction or plea entered? \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

R. Education

Beginning with high school, complete the following information regarding educational institutions you have attended:

Name and Address of Educational Institution	Dates Attended	Degrees/Certifications Received
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[ATTACH ADDITIONAL SHEETS IF NECESSARY]

**III. FAMILY INFORMATION**

A. Are you currently married?

Yes \_\_\_\_\_ No \_\_\_\_\_

B. Date of marriage: \_\_\_\_\_

C. Has your spouse filed a loss of consortium claim in connection with this claim?

Yes \_\_\_\_\_ No \_\_\_\_\_

D. 1. Spouse's name: \_\_\_\_\_

2. Spouse's date of birth: \_\_\_\_\_

3. Spouse's occupation: \_\_\_\_\_

4. Spouse's current address: \_\_\_\_\_

E. Have you had any prior marriages?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, for each marriage, state the following:

Prior Spouse's Name: \_\_\_\_\_

Prior Spouse's Last Known address: \_\_\_\_\_

Prior Spouse's Occupation During the Marriage: \_\_\_\_\_

Date the Marriage Was Terminated: \_\_\_\_\_

How the Marriage Was Terminated: \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

F. Complete the following regarding your mother:

Mother's Name and Current Address:

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Mother's Age (or Age at Death): \_\_\_\_\_

Current Condition of Mother's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Mother Held While You Resided in the Same Home: \_\_\_\_\_

G. Complete the following regarding your father:

Father's Name and Current Address:

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Father's Age (or Age at Death): \_\_\_\_\_

Current Condition of Father's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Father Held While You Resided in the Same Home: \_\_\_\_\_

H. Complete the following regarding your siblings, if any:

1. Sibling's Name and Current Address:

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Sibling's Age (or Age at Death): \_\_\_\_\_

Current Condition of Sibling's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Sibling Held While You Resided in the Same Home: \_\_\_\_\_

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2. Sibling's Name and Current Address:

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Sibling's Age (or Age at Death): \_\_\_\_\_

Current Condition of Sibling's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Sibling Held While You Resided in the Same Home: \_\_\_\_\_

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3. Sibling's Name and Current Address:

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Sibling's Age (or Age at Death): \_\_\_\_\_

Current Condition of Sibling's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Sibling Held While You Resided in the Same Home: \_\_\_\_\_

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4. Siblings Name and Current Address:

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Sibling's Age (or Age at Death): \_\_\_\_\_

Current Condition of Sibling's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Jobs Sibling Held While You Resided in the Same Home: \_\_\_\_\_

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[ATTACH ADDITIONAL SHEETS IF NECESSARY]

I. Do you have any children (whether by a current or prior marriage or relationship)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state the number of children: \_\_\_\_\_

If so, for each child, state the following:

1. Child's Name and Current Address:

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Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

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2. Child's Name and Current Address:

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Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

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3. Child's Name and Current Address:

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Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

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[ATTACH ADDITIONAL SHEETS IF NECESSARY]

J. Has any parent, grandparent, sibling or child been diagnosed with any cancer, lung disease, breathing difficulty or heart condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, identify each such person below and provide the information requested.

1. Name and Current Address:

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Diagnosis: \_\_\_\_\_

2. Name and Current Address:

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Diagnosis: \_\_\_\_\_

3. Name and Current Address:

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Diagnosis: \_\_\_\_\_

#### IV. EMPLOYMENT HISTORY

A. With respect to all of your present and past employment, please state the following:

1. The employer's name, the employer's address, and the starting and ending date of your employment;
2. The location, job site, or facility at which you worked, including:
  - i. the address by city and state;
  - ii. the inclusive dates of work for each facility or location;
3. Your occupation, titles, and duties for each employer identified above, specifying all pertinent dates and your reason for leaving said employer.

- B. 1. If you worked at the Gavin Landfill, do you allege that you were exposed to CCRs during your work?

Yes \_\_\_\_ No \_\_\_\_

2. If you did not work at the Gavin Landfill, please state the manner by which you allege you were exposed to CCRs from the Gavin Landfill:

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3. If you allege that you were exposed through a person who worked at the Gavin Landfill, the identity of that person and your relationship to them:

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4. The dates of your alleged exposure to CCRs from the Gavin Landfill:

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**V. MEDICAL INFORMATION**

- A. Describe each illness, disease or condition which you allege is caused by exposure to CCRs, and the date of each diagnosis:

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- B. 1. Have you had discussions with any health care provider about whether your illness, disease or condition is related to CCR exposure?

Yes \_\_\_\_\_ No \_\_\_\_\_ I do not recall \_\_\_\_\_

2. Identify the health care provider(s) with whom you have had these discussions:

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Name

---

Address

---

Telephone Number

---

Name

---

Address

---

Telephone Number

---

Name

---

Address

---

Telephone Number

- C. 1. Have you received treatment of any kind for any illness, disease or condition that you allege was caused by exposure to CCRs?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, identify the health care provider(s) and/or health care facility (e.g., hospital or clinic] from whom and where such treatments have been received;

---

Name

---

Address

---

Telephone Number

**VI. SMOKING HISTORY**

A. Please answer the following:

1. Have you ever smoked cigarettes? Yes \_\_\_\_ No \_\_\_\_
2. If yes, year began \_\_\_\_\_ and year ended \_\_\_\_\_.
3. Average pack(s) per day?
4. List the brands of cigarettes you smoked (if you recall):

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**VII. ALCOHOL CONSUMPTION HISTORY**

A. Please answer the following:

1. Have you ever consumed alcohol (i.e., beer, wine, whiskey, etc.)?  
Yes \_\_\_\_ No \_\_\_\_
2. If yes, year began \_\_\_\_\_ and year ended \_\_\_\_\_
3. Average drinks per day? (If there is a distinction for periods of life explain: e.g., between the ages of 20 and 30, 4 drinks per day, but now 2 drinks per day).
4. Have you ever been treated for alcoholism? Yes \_\_\_\_ No \_\_\_\_

**VIII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION**

List the name and address of each of the following:

A. Your current family physician:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Since When

B. Each health care provider who has seen or treated you in the past fifteen (15) years:

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

2.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

---

City, State, Zip Code

---

Telephone Number

3.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

4.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

C. Each hospital where you have received inpatient treatment during the past fifteen (15) years:

1.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

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Telephone Number

2.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

3.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Each hospital or health care facility where you have received outpatient treatment (including treatment in an emergency room) during the past fifteen (15) years:

1. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

2. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

3. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

---

City, State, Zip Code

---

Telephone Number

4.

---

Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

5.

---

Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- E. To the best of your knowledge, list each pharmacy or drugstore where you have had prescriptions filled during the past ten (10) years:

1.

---

Name

---

Street Address

---

City, State, Zip Code

---

Telephone Number

2.

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Name

---

Street Address

---

City, State, Zip Code

---

Telephone Number

3.

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Name

---

Street Address

---

City, State, Zip Code

---

Telephone Number

4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

5. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

F. If you have submitted a claim for Social Security disability benefits within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim filed,

1. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

2. \_\_\_\_\_  
Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- \_\_\_\_\_
- Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- G. If you have submitted a claim for Workers' Compensation within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim.

1. \_\_\_\_\_  
Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- If you were represented by counsel please provide:
- \_\_\_\_\_
- Attorney's Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- \_\_\_\_\_
- Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

H. Have you ever made a claim to, or sought coverage from, any insurance company (e.g., private personal health insurance, employer provided health insurance, group or family health insurance, parents' health insurance) for any of the following conditions:

Condition	Yes	No	If yes, the date that the claim was made	If yes, the name of the insurance company to which the claim was made
Angina				
Arteriosclerosis (hardening of the arteries)				
Arthritis				
Asthma				
Black lung				
Bladder Stones				
Cancer - Bladder				
Cancer - Brain				
Cancer - Breast				
Cancer - Colon				
Cancer - Esophageal				
Cancer - Gastrointestinal				
Cancer - Laryngeal				
Cancer - Leukemia				
Cancer - Lung				
Cancer - Lymphoma/ Hodgkin's disease				
Cancer - Oral, Head & Neck				
Cancer - Ovarian				
Cancer - Prostate				
Cancer - Skin				
Cancer - Stomach				
Cancers – all other types				
Congestive heart failure (CHF)				
Cough				
Emphysema				
Fibrosis				
Fractured ribs				
Gastrointestinal Disease				

Condition	Yes	No	If yes, the date that the claim was made	If yes, the name of the insurance company to which the claim was made
Heart - by-pass surgery				
Heart - Disease				
Heart - Myocardial infarction (heart attack)				
Heart -- other conditions				
Heart - transplant				
Hypertension (high blood pressure)				
Jaundice				
Liver disease				
Memory Loss				
Nodules of the breast, thyroid or throat				
Obesity				
Obstructive Lung Disease (COPD)				
Pneumoconiosis				
Polyps in the colon				
Pulmonary edema				
Pulmonary/lung disorders				
Raynaud's Disease				
Restrictive Airways Impairment				
Shortness of breath				
Skin Conditions				
Sleep Disorders				
Sternum or chest area blunt trauma				
Tuberculosis				

DECLARATION

I declare that all the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief at this time. If I recall or discovery additional information, I will promptly provide the information to supplement or correct these responses.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# EXHIBIT B





2. List all other addresses where you have lived for the last thirty (30) years:

Street Address	City	State	Zip Code	Dates at address
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Street Address	City	State	Zip Code	Dates at address
----------------	------	-------	----------	------------------

Street Address	City	State	Zip Code	Dates at address
----------------	------	-------	----------	------------------

Street Address	City	State	Zip Code	Dates at address
----------------	------	-------	----------	------------------

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Employment

1. \_\_\_\_\_  
Name of Current or Last Employer  
  
\_\_\_\_\_  
Name of Current or Last Supervisor or Superior  
  
\_\_\_\_\_  
Current or Last Employer Address  
  
\_\_\_\_\_  
Current or Last Employer Telephone Number  
  
\_\_\_\_\_  
Dates of Current or Last Employment  
  
\_\_\_\_\_  
Current or Last Occupation

- E. Social Security, Visa or Green Card Number: \_\_\_\_\_
- F. Date of Birth: \_\_\_\_\_
- G. Place of Birth: \_\_\_\_\_
- H. Date of Death: \_\_\_\_\_

I. Cause of Death: \_\_\_\_\_

J. Are you a Citizen of the United States?

Yes \_\_\_\_\_ No \_\_\_\_\_

K. Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

L. Have you ever served in any branch of the U. S. Military?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state:

1. What branch and the dates of service: \_\_\_\_\_

M. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any physical, psychological or emotional injury?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed:

1. Year claim was filed: \_\_\_\_\_

2. Where claim was filed: \_\_\_\_\_

3. Claim/docket number, if applicable: \_\_\_\_\_

4. Nature of disability: \_\_\_\_\_

5. Period of disability: \_\_\_\_\_

6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

N. Have you been convicted of or pled guilty to a crime involving dishonesty or false statement (e.g., perjury) in the last 10 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so:

1. What was the offense? \_\_\_\_\_

2. What was the case number? \_\_\_\_\_
3. What was the date of conviction or plea? \_\_\_\_\_
4. In what court was the conviction or plea entered? \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

O. Education

Beginning with high school, complete the following information regarding educational institutions you have attended:

Name and Address of Educational Institution	Dates Attended	Degrees/Certifications Received

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

**III. FAMILY INFORMATION**

- A. Are you currently married?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Date of marriage: \_\_\_\_\_
- C. Has your spouse filed a loss of consortium claim in connection with this claim?  
Yes \_\_\_\_\_ No \_\_\_\_\_
- D.
  1. Spouse's name: \_\_\_\_\_
  2. Spouse's date of birth: \_\_\_\_\_
  3. Spouse's occupation: \_\_\_\_\_
  4. Spouse's current address: \_\_\_\_\_
- E. Have you had any prior marriages?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If so, for each marriage, state the following:

Prior Spouse's Name: \_\_\_\_\_

Prior Spouse's Last Known address: \_\_\_\_\_

\_\_\_\_\_  
Prior Spouse's Occupation During the Marriage: \_\_\_\_\_

Date the Marriage Was Terminated: \_\_\_\_\_

How the Marriage Was Terminated: \_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

F. Do you have any children (whether by a current or prior marriage or relationship)?

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, state the number of children: \_\_\_\_\_

If so, for each child, state the following:

1. Child's Name and Current Address:

\_\_\_\_\_  
\_\_\_\_\_

Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

\_\_\_\_\_

If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

\_\_\_\_\_

2. Child's Name and Current Address:

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Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

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3. Child's Name and Current Address:

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Child's Age (or Age at Death): \_\_\_\_\_

Current Condition of Child's Health, Including Any Specific Medical Problems:

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If Applicable, Cause of Death: \_\_\_\_\_

Does this child currently reside with you? Yes \_\_\_\_\_ No \_\_\_\_\_

Jobs Child Held While You Resided in the Same Home: \_\_\_\_\_

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[ATTACH ADDITIONAL SHEETS IF NECESSARY]

G. Has any child been diagnosed with any cancer, lung disease, breathing difficulty or heart condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, identify each such person below and provide the information requested.

1. Name and Current Address:

---

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Diagnosis: \_\_\_\_\_

2. Name and Current Address:

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Diagnosis: \_\_\_\_\_

3. Name and Current Address:

---

---

Diagnosis: \_\_\_\_\_

#### IV. SMOKING HISTORY

A. Please answer the following:

1. Have you ever smoked cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, year began \_\_\_\_\_ and year ended \_\_\_\_\_.

3. Average pack(s) per day? \_\_\_\_\_

4. List the brands of cigarettes you smoked (if you recall):

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**PART II**

**Are you claiming anything other than general loss of consortium (e.g. loss of household services, loss of love and companionship)?**

Yes \_\_\_\_ No \_\_\_\_

**IF YES, PLEASE COMPLETE SECTIONS V-VII:**

**V. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION**

List the name and address of each of the following:

A. Your current family physician:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Since When

B. Each health care provider who has seen or treated you in the past fifteen (15) years:

1. \_\_\_\_\_

Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

2.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

3.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

4.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

C. Each hospital where you have received inpatient treatment during the past fifteen (15) years:

1. \_\_\_\_\_  
Name

\_\_\_\_\_

Specialty

\_\_\_\_\_

Street Address

\_\_\_\_\_

City, State, Zip Code

\_\_\_\_\_

Telephone Number

2. \_\_\_\_\_  
Name

\_\_\_\_\_

Specialty

\_\_\_\_\_

Street Address

\_\_\_\_\_

City, State, Zip Code

\_\_\_\_\_

Telephone Number

3. \_\_\_\_\_  
Name

\_\_\_\_\_

Specialty

\_\_\_\_\_

Street Address

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City, State, Zip Code

---

Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

D. Each hospital or health care facility where you have received outpatient treatment (including treatment in an emergency room) during the past fifteen (15) years:

1.

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Name

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Specialty

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Street Address

---

City, State, Zip Code

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Telephone Number

2.

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Name

---

Specialty

---

Street Address

---

City, State, Zip Code

---

Telephone Number

3. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

4. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

5. \_\_\_\_\_  
Name  
\_\_\_\_\_  
Specialty  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_  
Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. To the best of your knowledge, list each pharmacy or drugstore where you have had prescriptions filled during the past ten (10) years: -

1. \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

2. \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

3. \_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

4.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

5.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

F. If you have submitted a claim for Social Security disability benefits within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim filed,

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Telephone Number

2. \_\_\_\_\_  
Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- \_\_\_\_\_
- Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

- G. If you have submitted a claim for Workers' Compensation within the past fifteen (15) years, state the name and address of the office which is most likely to have records concerning each claim.

1. \_\_\_\_\_  
Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- If you were represented by counsel please provide:
- \_\_\_\_\_
- Attorney's Name
- \_\_\_\_\_
- Street Address
- \_\_\_\_\_
- City, State, Zip Code
- \_\_\_\_\_
- Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

H. Have you ever made a claim to, or sought coverage from, any insurance company (e.g., private personal health insurance, employer provided health insurance, group or family health insurance, parents' health insurance) for any of the following conditions:

Condition	Yes	No	If yes, the date that the claim was made	If yes, the name of the insurance company to which the claim was made
Angina				
Arteriosclerosis (hardening of the arteries)				
Arthritis				
Asthma				
Black lung				
Bladder Stones				
Cancer - Bladder				
Cancer - Brain				
Cancer - Breast				
Cancer - Colon				
Cancer - Esophageal				
Cancer - Gastrointestinal				
Cancer - Laryngeal				
Cancer - Leukemia				
Cancer - Lung				
Cancer - Lymphoma/ Hodgkin's disease				
Cancer - Oral, Head & Neck				

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>If yes, the date that the claim was made</b>	<b>If yes, the name of the insurance company to which the claim was made</b>
Cancer - Ovarian				
Cancer - Prostate				
Cancer - Skin				
Cancer - Stomach				
Cancers – all other types				
Congestive heart failure (CHF)				
Cough				
Emphysema				
Fibrosis				
Fractured ribs				
Gastrointestinal Disease				
Heart - by-pass surgery				
Heart - Disease				
Heart - Myocardial infarction (heart attack)				
Heart – other conditions				
Heart - transplant				
Hypertension (high blood pressure)				
Jaundice				
Liver disease				

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>If yes, the date that the claim was made</b>	<b>If yes, the name of the insurance company to which the claim was made</b>
Memory Loss				
Nodules of the breast, thyroid or throat				
Obesity				
Obstructive Lung Disease (COPD)				
Pneumoconiosis				
Polyps in the colon				
Pulmonary edema				
Pulmonary/lung disorders				
Raynaud's Disease				
Restrictive Airways Impairment				
Shortness of breath				
Skin Conditions				
Sleep Disorders				
Sternum or chest area blunt trauma				
Tuberculosis				

**VI. MEDICAL INFORMATION**

A. What claim(s) are you making as a result of your spouse's alleged exposure to CCRs?:

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B. 1. Have you had discussions with any health care provider about whether any of these claims are related to your spouse's alleged CCR exposure?

Yes \_\_\_\_\_ No \_\_\_\_\_ I do not recall \_\_\_\_\_

2. Identify the health care provider(s) with whom you have had these discussions:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

C. Have you received treatment of any kind for any condition that you allege is related to your spouse's alleged exposure to CCRs?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, identify the health care provider(s) and/or health care facility (e.g., hospital or clinic) from whom and where such treatments have been received:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

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Name

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Address

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Telephone Number

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

**VII. HEALTH HISTORY**

A. Have you been unemployed for health reasons for 30 consecutive days or more within the last fifteen (15) years?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

If so, please state the following for each period:

1. First and last date of period of unemployment: \_\_\_\_\_
2. Reason for unemployment: \_\_\_\_\_
3. With respect to any period of unemployment identified above, identify all unemployment benefits claimed and received for that period of unemployment: \_\_\_\_\_  
\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

B. Were you ever discharged from the U.S. Military for any reason relating to your health, physical or mental condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state what that condition was: \_\_\_\_\_  
\_\_\_\_\_

C. Have you ever been rejected from military service for any reason relating to your health, physical or mental condition?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, state what that condition was: \_\_\_\_\_  
\_\_\_\_\_

D. Have you filed a Workers' Compensation claim within the past 15 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed;

1. Year claim was filed: \_\_\_\_\_
2. Where claim was filed: \_\_\_\_\_

3. Claim/docket number, if applicable: \_\_\_\_\_
4. Nature of disability: \_\_\_\_\_
5. Period of disability: \_\_\_\_\_
6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

E. Have you filed a Social Security disability claim within the past 15 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please state the following for each claim filed:

1. Year claim was filed: \_\_\_\_\_
2. Where claim was filed: \_\_\_\_\_
3. Claim/docket number, if applicable: \_\_\_\_\_
4. Nature of disability: \_\_\_\_\_
5. Period of disability: \_\_\_\_\_
6. Attorney, if any, who represented you (name, address and telephone number): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

[ATTACH ADDITIONAL SHEETS IF NECESSARY]

DECLARATION

I declare that all the information provided in this Fact Sheet is true and correct to the best of my knowledge, information and belief at this time. If I recall or discovery additional information, I will promptly provide the information to supplement or correct these responses.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date