NFL CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

SUPPLEMENTAL CLAIM FORM
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS

Use this Supplemental Claim Form if you are a **Retired NFL Football Player** or the **Representative Claimant** of a Retired NFL Football Player who has been paid a Monetary Award and you want to apply for a Supplemental Monetary Award in the NFL Concussion Settlement Program.

To be eligible for a Supplemental Monetary Award you must provide documents showing a new Qualifying Diagnosis that is different from and occurred after the Qualifying Diagnosis for which you previously received a Monetary Award. A Supplemental Claim Package must include: (a) this Supplemental Claim Form; (b) a Diagnosing Physician Certification Form signed by the Qualified MAF Physician or Qualified BAP Provider who made the new Qualifying Diagnosis; and (c) medical records supporting and reflecting the new Qualifying Diagnosis. You do not have to submit a new HIPAA Form or any proof of NFL Employment.

You must submit your Supplemental Claim Package no later than two years after the date of the new Qualifying Diagnosis.

I. RETIRED NFL FOOTBALL PLAYER INFORMATION

Settlement Program ID				
Player Name	First	M.I.	Last	Suffix
Player Date of Birth	--_____/--_____/----_____ (Month/Day/Year)			
Player Date of Death (if applicable)	--_____/--_____/----_____ (Month/Day/Year)			
Player Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen)	_____ - _____ - _____ **or** _____			
Player Mailing Address	Address 1			
	Address 2			
	City			
	State/Province	If Non-US:		
	Postal Code		Country	
Player Telephone	_____ - _____ - _____	**Player Email Address**		

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II. REPRESENTATIVE CLAIMANT INFORMATION

If you are a **Representative Claimant** of a deceased or legally incapacitated or incompetent Retired NFL Football Player fill out this Section II with your own information. If you are not a Representative Claimant, skip this section.

Representative Name	First	M.I.	Last	Suffix
Representative Date of Birth	--/--/---- (Month/Day/Year)			
Representative Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen)	___ ___ ___ **or** ___			
Representative Mailing Address	Address 1			
	Address 2			
	City			
	State/Province / If Non-US:			
	Postal Code		Country	
Representative Telephone	___ - ___ - ___	**Representative Email Address**		

III. LAWYER INFORMATION

If a lawyer represents you on this claim, enter the lawyer's information in this Section III. If you do not have your own lawyer, skip this section.

Lawyer Name	First	M.I.	Last	Suffix
Law Firm Name				
Lawyer Mailing Address	Address 1			
	Address 2			
	City			
	State/Province / If Non-US:			
	Postal Code		Country	
Lawyer Telephone	___ - ___ - ___	**Lawyer Email Address**		

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IV. QUALIFYING DIAGNOSIS

Check the Qualifying Diagnosis for which the Retired NFL Football Player seeks a Supplemental Monetary Award and provide information requested. If the Retired NFL Football Player was diagnosed with Level 2 Neurocognitive Impairment in the Baseline Assessment Program ("BAP"), you must provide the name of **both** the diagnosing neuropsychologist and the diagnosing board-certified neurologist.

Qualifying Diagnosis	Date of Diagnosis	State of Domicile at Time of Diagnosis
☐ **Level 2 Neurocognitive Impairment**	--/--/---- (Month/Day/Year)	_____ (State)

Diagnosing medical professional:				
Name	First	M.I.	Last	Suffix

Second diagnosing medical professional (if diagnosis was made through the BAP):				
Name	First	M.I.	Last	Suffix

☐ **Alzheimer's Disease**	--/--/---- (Month/Day/Year)	_____ (State)

Diagnosing medical professional:				
Name	First	M.I.	Last	Suffix

☐ **Parkinson's Disease**	--/--/---- (Month/Day/Year)	_____ (State)

Diagnosing medical professional:				
Name	First	M.I.	Last	Suffix

☐ **ALS (Amyotrophic Lateral Sclerosis, or "Lou Gehrig's Disease")**	--/--/---- (Month/Day/Year)	_____ (State)

Diagnosing medical professional:				
Name	First	M.I.	Last	Suffix

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V. ADDITIONAL MEDICAL INFORMATION

A. Stroke

The Settlement Agreement requires a 75% Offset against any Monetary Award if the Retired NFL Football Player had a Stroke either before or after the time he played NFL Football, unless you can show by clear and convincing evidence that the Qualifying Diagnosis for which an award is sought is not causally related to the Stroke. A medically diagnosed Stroke does not include a transient cerebral ischemic attack and related syndromes.

Note: If this 75% Offset for a Stroke was applied to your previous award, then it may be applied to any later Supplemental Monetary Award.

If the player has had a Stroke after the Qualifying Diagnosis on which you were paid an award, you must tell us about it now. Check the appropriate boxes below regarding any Strokes.

☐ **NO** Check NO if the Retired NFL Football Player has not had a Stroke after the Qualifying Diagnosis on which you were paid an award. Then go to Section V.B.

☐ **YES** Check YES if the Retired NFL Football Player has had a Stroke after the Qualifying Diagnosis on which you were paid an award and provide information about the Stroke in the space below. Then go to Section V.B.

Date of Stroke	--_____/--_____/----_____ (Month/Day/Year)

Medical professional who diagnosed the Stroke:

Name	First	M.I.	Last	Suffix

☐ If you answered YES, check here if you believe that this Stroke was not causally related to the Qualifying Diagnosis for which you are claiming a Supplemental Monetary Award. If we have information regarding a Stroke and you do not check here, we will have to apply the Offset and reduce any Supplemental Monetary Award by 75%.

B. Traumatic Brain Injury

The Settlement Agreement requires a 75% Offset against any Monetary Award if the Retired NFL Football Player had a *severe* traumatic brain injury unrelated to NFL Football play during or after the time he played NFL Football, unless you can show by clear and convincing evidence that the Qualifying Diagnosis for which an award is sought is not causally related to the traumatic brain injury. A severe traumatic brain injury is one that caused the Retired NFL Football Player to lose consciousness for more than 24 hours.

Note: If this 75% Offset for a traumatic brain injury was applied to your previous award, then it may be applied to any later Supplemental Monetary Award.

If the player has had a traumatic brain injury after the Qualifying Diagnosis on which you were paid an award, you must tell us about it now. Check the appropriate boxes below regarding any traumatic brain injury.

☐ **NO** Check NO if the Retired NFL Football Player has not had a severe traumatic brain injury after the Qualifying Diagnosis on which you were paid an award. Then go to Section VI.

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☐ **YES** Check YES if the Retired NFL Football Player has had a severe traumatic brain injury after the Qualifying Diagnosis on which you were paid an award and provide information about it in the space below. Then go to Section VI.

Date of Traumatic Brain Injury	--/--/---- (Month/Day/Year)

Medical professional who diagnosed the Traumatic Brain Injury:

Name	First	M.I.	Last	Suffix

☐ If you answered YES, check here if you believe that the traumatic brain injury was not causally related to the Qualifying Diagnosis for which you are claiming a Supplemental Monetary Award. If we have information regarding a traumatic brain injury and you do not check here, we will have to apply the Offset and reduce any Supplemental Monetary Award by 75%.

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VI. MEDICARE, MEDICAID AND OTHER LIEN INFORMATION

Under Article XI of the Settlement Agreement, the Lien Resolution Administrator, with assistance from the Claims Administrator, is administering the process to identify, verify and satisfy any Liens that may apply to your Supplemental Monetary Award. If you or the Lien Resolution Administrator identifies a potential Lien against your Supplemental Monetary Award and the Lien Resolution Administrator confirms the validity and final amount of such Lien(s), we are required to deduct those amounts from your Supplemental Monetary Award along with any other deductions required by state or federal law.

We pre-filled the answers in this Section VI from your previously submitted Claim Form. If any of this information has changed, you must update it when submitting this Supplemental Claim Form.

Are you aware of a potential Lien that could be asserted against your Supplemental Monetary Award?

☐ **YES** If you answered Yes, fill out the appropriate questions in this Section VI. Then go to Section VII.

☐ **NO** If you answered No, go to Section VII.

A. Medicare

1. If the Retired NFL Football Player is now enrolled, or has been enrolled at any time, in **Medicare Part A** or **Medicare Part B** program(s), provide the following information.

   HICN (Medicare Claim #):

   _____

   Enrollment date: __/__/____
   (Month/Day/Year)

2. If the Retired NFL Football Player is now enrolled, or has been enrolled at any time, in a **Medicare Part C** program (for example, a Medicare Advantage, Medicare cost, Medicare healthcare prepayment plan benefits, or similar Medicare plan administered by private entities), provide the following information.

   Name of Medicare Part C plan:

   _____

   Member number for Medicare Part C plan:

   _____

   Enrollment date: __/__/____
   (Month/Day/Year)

3. If the Retired NFL Football Player is now enrolled, or has been enrolled at any time, in a **Medicare Part D** program (prescription drug benefits), provide the following information.

   Name of Medicare Part D Plan:

   _____

   Member number of Medical Part D Plan:

   _____

   Enrollment date: __/__/____
   (Month/Day/Year)

B. Medicaid

1. If the Retired NFL Football Player is currently enrolled in a state Medicaid Program, provide the following information.

   Medical ID number: _____

   State of Issuance: _____

   Enrollment Date: --/--/---- (Month/Day/Year)

2. If the Retired NFL Football Player has been enrolled in any other state Medicaid Program at any time, provide the following information.

   Medical ID number: _____

   State of Issuance: _____

   Enrollment Date: --/--/---- (Month/Day/Year)

C. Department of Veterans Affairs, TRICARE, or Indian Health Service

Check any of the following federal healthcare programs that the Retired NFL Football Player has enrolled in or has been entitled to receive benefits from at any time. If you check any of the programs below, provide the required information about each program.

☐ **Department of Veterans Affairs healthcare or prescription drug benefits**

Claim Number:

_____

Enrollment Dates: --/--/---- (Month/Day/Year) **TO** --/--/---- (Month/Day/Year)

Branch: _____

Sponsor: _____

Sponsor SSN: _____ - _____ - _____

Treating Facility: _____

☐ **TRICARE health care or prescription drug benefits**

Claim Number:

_____

Enrollment Dates: --/--/---- (Month/Day/Year) **TO** --/--/---- (Month/Day/Year)

Branch: _____

Sponsor: _____

Sponsor SSN: _____ - _____ - _____

Treating Facility:

☐ **Indian Health Service healthcare or prescription drug benefits**

Claim Number: _____

Enrollment Dates: --/--/---- **TO** --/--/----
(Month/Day/Year) (Month/Day/Year)

Branch: _____

Sponsor: _____

Sponsor SSN: _____ - _____ - _____

Tribe:

_____

Treating Facility:

_____

D. Other Governmental Payor

If at any time the Retired NFL Football Player was entitled to receive medical items, services, and/or prescription drugs from any federal, state, or other governmental body, agency, department, plan, program, or entity that administers, funds, pays, contracts for, or provides medical items, services, and/or prescription drugs not previously listed above, provide the following information.

Name of Plan/Entity:

_____

Policyholder Name:

_____

Policy Number:

_____

Medical Condition Covered by Plan/Entity: _____

E. Private Healthcare Insurance

If the Retired NFL Football Player has received medical treatment for the new Qualifying Diagnosis that was covered by a private healthcare insurance plan or other form of payment, provide the following information for every such plan or entity.

Name of Plan/Entity:

_____

Policyholder Name:

_____

Policy Number:

_____

Medical Condition Covered by Plan/Entity: _____

F. Other Lien Information

Identify any known Lien of any nature whatsoever not identified above. Such a Lien may include, without limitation, any mortgage, lien, pledge, charge, security interest, or legal encumbrance held by any person or entity (such as an attorney, child support agency, federal or state tax agency, or judgment creditor), where that person or entity may be legally entitled to a share of any Supplemental Monetary Award that you may receive.

You also must attach to this Supplemental Claim Form a copy of the letter, form, or writing from such person or entity informing you of this Lien.

Name of Lienholder: _____

Amount of Lien: $_____ , _____ . _____

Contact Information for Lienholder: _____

_____

_____

Nature of Lien: _____

_____

VII. BANKRUPTCY INFORMATION

Has the Retired NFL Football Player ever been a debtor in a bankruptcy proceeding?

☐ **YES** If you answered Yes, provide additional information about the bankruptcy proceeding. Then go to Section IX to sign this Supplemental Claim Form.

☐ **NO** If you answered No, go to Section IX to sign this Supplemental Claim Form.

U.S. Bankruptcy Court, _____ District of _____
(District Name) (State)

Case Number: _____ – _____

Chapter: ☐ Chapter 7 ☐ Chapter 11 ☐ Chapter 12 ☐ Chapter 13

Date bankruptcy was filed: --_____/--_____/----_____
(Month/Day/Year)

If closed, date bankruptcy was closed: --_____/--_____/----_____
(Month/Day/Year)

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VIII. DUTY TO UPDATE

You must promptly notify the Claims Administrator of any changes or updates to the information in your Supplemental Claim Form, including any changes in your medical condition, whether a person or entity asserts a Lien or entitlement to any monies received under the Settlement Agreement, and any change in your mailing address or contact information.

IX. SIGNATURE

By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this Supplemental Claim Form, and in any attachments, is true and correct to the best of my knowledge, information, and belief.

Signature		**Date**	-- / -- / ---- (Month/Day/Year)
Printed Name	**First**	**M.I**	**Last**