INSTRUCTIONS FOR FILLING OUT FLINT WATER SETTLEMENT SIGNATURE ATTESTATION FORM

- Please read through form carefully.
- Some fields are required and will not let you proceed until you have completed that field.
- All the information being requested is for the Claimant. If you are completing on behalf of the Claimant, please provide their information and not your own.

SECTION II – CLAIMANT/INJURY PARTY INFORMATION:

1. Please write in your name. If you are filling this out on behalf of a claimant please provide their name here.
2. Please write in your date of birth. If you are filling this out on behalf of a claimant please provide their date of birth.
3. Please write in your social security number. If you are filling this out on behalf of a claimant please provide their social security number. Please provide the entire number and not just the last four digits.
4. Please indicate whether the claimant is a male or female.

SECTION III – GOVERNMENT HEALTH PLAN INFORMATION:

Please complete this section based upon information at the time of exposure and not now if the information is different.

1. Please answer "yes" or "no" if you were covered by a government health plan other than Medicare of Medicaid at the time you were exposed to the Flint Water.
2. If you were enrolled in TRICARE or the VA please provide the name of the military branch in which you served.
3. If you are a dependent on the plan please provide the name of the military sponsor, their date of birth and the last four digits of their SSN.
4. If you received treatment at a VA hospital/facility please provide the name and address of the hospital/facility.
5. If you received treatment through Indian Health Service, please provide the tribal affiliation and the City/State where treated.

SECTION IV – PRIVATE AND MEDICARE PART C LIEN RESOLUTION:

Please complete this section based upon information at the time of exposure and not now if the information is different.

(Continued on next page.)

1. If you are completing online this is a dropdown choice – please select the appropriate plans. If completing a paper form please write in all plans that you had during the time of exposure. Please write out the full name of the plan, ie. Blue Cross Blue Shield of Michigan.
2. Please write in the Health Plan ID.
3. Please write in the type of health plan; Group Health or Medicare Part C.
4. If you selected Group Health please provide the name of your employer.
5. Please answer "yes" or "no" to whether you have ever received a notice from your health insurance plan or from a health care provider of a medical lien regarding your Flint Water related injury.
6. If you answered "yes", please email a copy of that notice to: liennoticesubmission@archersystems.com.

VERIFICATION and SIGNATURE:

If you are completing this form online you do not need to sign this form. The Signature Attestation Form that you will complete and sign via Doc-U-Sign will be used as your signature for this form.
If you are completing a paper version of this form you will need to sign and date.

BEFORE YOU HIT SUBMIT OR RETURN YOUR PACKET IN THE MAIL, PLEASE REMEMBER TO:

- COMPLETE ALL THE SECTIONS THAT ARE APPLICABLE TO YOU.
- IF YOU ARE RETURNING BY MAIL – SIGN THE FORM
- IF YOU ARE SUBMITTING ONLINE YOU WILL NOT SIGN THIS FORM BUT WILL ONLY SIGN THE SIGNATURE ATTESTATION FORM. YOU CAN SUBMIT THIS FORM WITHOUT A SIGNATURE.