ELNY Hardship Fund Claims Administrator
PO Box 3207
Portland, OR 97208-3207

<<Mail ID>>
<<Name 1>>
<<Name 2>>
<<Business>>
<<Rep>>
<<Address 1>>
<<Address 2>>
<<City>><<State>><Zip>>
<<Foreign Country>>

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For help in completing this form, call us toll-free **1-888-809-2254** or email **questions@elnyhardshipfund.com**.

Instructions - Application for Participation in the ELNY Hardship Fund

Filing an Application Online

To file your application online please go to www.ELNYHardshipFund.com and enter the following credentials:

Mail ID:
PIN:

Upon logging in to the "Submit Your Application Online" page for the first time, you will be asked to change your password. Remember this password and please be sure to keep your Mail ID if you plan to file your application over the course of a few days or weeks. You will be allowed to work on your Application, save your work and return at a later date to continue. Please note that once an application is submitted, you will not be able to make any edits or changes nor will you be able to re-submit supporting documentation.

Terminology

- "Injured Party" means either (a) the person who was injured in an accident/incident and received the annuity originally; or (b) the person who originally received the annuity because someone else was injured or killed in an accident/incident.
- "Current Annuity Payee" means the person in whose name annuity payments now are issued. This may be the Injured Party or someone else.
- "SSN" means Social Security Number.
- Ⓓ Supporting documentation may be required.

NOTE: In addition to the documents specifically requested in this application, the ELNY Hardship Fund Claims Administrator reserves the right to request additional information or further documentation.

This Application Form consists of Six Sections:

- Section 1: Background Information
- Section 2: Current Condition
- Section 3: Contact Information
- Section 4: Certification
- Section 5: Release of the ELNY Hardship Fund from All Claims and Liability
- Section 6: Authorization for Release of Information (HIPAA)

When completing this Application Form:

- Print clearly using blue or black ink.
- Please do not staple.
- Never send originals of any documents you include – submit copies.
- Clearly label any documents you enclose with your name and SSN.

To be eligible for relief, you must:

- Submit this Application Form by September 15, 2012.
- Send the Application Form to: **ELNY Hardship Fund Claims Administrator**
  PO BOX 3207
  Portland, OR 97208-3207
- Sign the Certification on page 14, the Release form on page 15, and the HIPAA Authorization form on page 16.

The deadline date will be met only if one of the following methods is used:

1. First class mail must be postmarked on or before September 15, 2012; or
2. Courier or overnight delivery must have a deposit date on or before September 15, 2012; or
3. Electronic mailing must have a transmission date on or before September 15, 2012.

Application Forms, paper and electronic, are limited to **one** per payee.

For any answers or statements, you may attach additional sheets for your explanation, as necessary. Clearly label any additional documents with your name and SSN.

Section 1: **Background Information**

Section 1.1: Applicant Information

Are you the: ☐ Injured Party ☐ Current Annuity Payee ☐ Other ______________________

First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____ | Alternate Phone Number ___ – ___ – ____

Section 1.2: Current Annuity Payee Information

Who is the Current Annuity Payee (person, entity or institution to whom the check is payable)?

First Name | MI | Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____ | Alternate Phone Number ___ – ___ – ____

SSN ___ – __ – ____ | Employer Identification Number (EIN) __ – _______

If the Current Payee is not the Injured Party, what is the relationship of the Current Payee to the Injured Party for whose benefit the ELNY annuity was purchased? ______________________________

____

____

For help in completing this form,
call us toll-free **1-888-809-2254** or
email **questions@elnyhardshipfund.com**.

Please list all the payments provided for under the structured settlement, including recurring monthly or other periodic payments (including payments subject to Cost of Living Adjustments) and scheduled lump sum payments.

____

____

(D) ***DOCUMENTATION:*** **Please provide a copy of the Settlement Agreement and annuity documents, if available.**

Section 1.3: Annuity Information

Was the original annuity factored or otherwise assigned to a third party? ☐ Yes ☐ No ☐ Don't Know

If so, when? ______________________

If so, how much of the annuity was factored or assigned (all or part)? ______________________

To whom? ______________________

*Provide the above information for all such transfers. Use a separate sheet, if needed.

(D) ***DOCUMENTATION:*** **Please provide a copy of the court order approving the transfer, if any.**

Please provide the following information about the third party:

First Name | MI | Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____ | Alternate Phone Number ___ – ___ – ____

Did the Settlement Agreement provide for a "qualified assignment" of the obligation to make future payments? ☐ Yes ☐ No

If so, to whom? ______________________

Did the Settlement Agreement provide for a release of the obligation to make future settlement payments if there was a qualified assignment? ☐ Yes ☐ No

Has the applicant received any communication from an annuity owner indicating that the owner will cover shortfalls under the annuity? ☐ Yes ☐ No

Has the applicant received any communication from any property, casualty or insurance company about this matter? ☐ Yes ☐ No

If Yes, please explain. ______________________

____

(D) ***DOCUMENTATION:*** **Please provide any documentation, if available.**

For help in completing this form, call us toll-free **1-888-809-2254** or email **questions@elnyhardshipfund.com**.

Section 1.4: Injured Party Information

Is the person for whose benefit the annuity was originally purchased still alive? ☐ Yes ☐ No

If your answer is "No", proceed to Section 1.4.1. If your answer is "Yes", proceed to Section 1.4.2.

Section 1.4.1

If the person is not living, please provide information:

Date of Death (MM-DD-YYY)

M M – D D – Y Y Y Y

Name of person, entity, or institution to whom the payments are currently being made:

First Name | MI | Last Name

Business Name and/or other Entity (if applicable)

Relationship to the original injured party

Mailing Address, including unit or box number

City | State | Zip Code

Email

Phone Number – – | Alternate Phone Number – –

Ⓓ ***DOCUMENTATION:*** **Please provide a copy of the death certificate of the person for whose benefit the annuity was originally purchased. You may proceed to Section 1.5.**

Section 1.4.2

What is the Injured Party's date of birth?

M M – D D – Y Y Y Y

Is the Injured Party married or in a domestic partnership? ☐ Yes ☐ No

If *Yes*, please provide contact information for the spouse or domestic partner:

First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number – – | Alternate Phone Number – –

Does the Injured Party have children or other persons for whom the Injured Party is legally obligated to provide support? ☐ Yes ☐ No

If Yes:

What is the amount of this support on a yearly basis? **$** ______ . __

Please provide names and contact information for each person. Attach additional sheets, if necessary.

Person 1: First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____ | Alternate Phone Number ___ – ___ – ____

Date of Birth (MM/DD/YYYY) __ – __ – ____

What is the reason for the Injured Party's obligation to pay this person (court ordered obligation, third party obligation, etc.)?

____

____

____

Person 2: First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____ | Alternate Phone Number ___ – ___ – ____

Date of Birth (MM-DD-YYYY) __ – __ – ____

What is the reason for the Injured Party's obligation to pay this person (court ordered obligation, third party obligation, etc.)?

____

____

____

Section 1.5: Income & Financial Support

Please check all sources of financial support for the Injured Party (if alive) or the Current Payee on a yearly basis. Next to each item checked, please indicate the amount of the payment and how often payment is received (i.e., monthly, yearly, etc.). This can include, but is not limited to the following:

	Income/Financial Support Type	Amount of Payment	Frequency
☐	Income from employment of any type	$ ______ . __	______
☐	Dividends	$ ______ . __	______
☐	Social Security	$ ______ . __	______
☐	Alimony or child support	$ ______ . __	______
☐	Interest	$ ______ . __	______
☐	Gifts, Awards, Winnings	$ ______ . __	______
☐	Workers' Compensation	$ ______ . __	______
☐	Disability payments	$ ______ . __	______
☐	Medicare	$ ______ . __	______
☐	Any other federal or state funding source	$ ______ . __	______
☐	IRA or other pension	$ ______ . __	______
☐	Medicaid	$ ______ . __	______
☐	Inheritance	$ ______ . __	______
☐	Scholarships/Loans	$ ______ . __	______
☐	Other Annuities	$ ______ . __	______

☐ Other (If other, please explain). ______________________________

____

____

Ⓓ ***DOCUMENTATION:*** **Please provide a list of the Injured Party's/Current Payee's Assets and Liabilities. Please include details regarding the frequency of any payments you receive or make. Please use a separate sheet.**

Ⓓ ***DOCUMENTATION:*** **Please provide any documents that show the Injured Party's/Current Payee's financial support and income, including, but not limited to, the following:**

- W2 or 1099 forms
- Last two (2) years' Federal tax returns
- Court orders for alimony or child support
- Federal and/or state payments

What are the monthly expenses of the Injured Party (if alive) or Current Payee?

Food **$** ______ . __

Medical: **$** ______ . __

Housing: **$** ______ . __

Transportation: **$** ______ . __

Care to meet daily needs: **$** ______ . __

Educational or vocational programs: **$** ______ . __

Is the Injured Party/Current Payee entitled to receive benefits from any source but is not currently receiving those benefits? ☐ Yes ☐ No

If *Yes*, explain the source and the reason that payments are not being received.

What non-recurring costs for the benefit of the Injured Party/Current Payee should be considered?

How is the Injured Party/Current Payee currently meeting these costs?

Does any other person provide support for the benefit of the Injured Party/Current Payee (including legal obligations)? If so, please describe.

Section 1.6: Current Payee Information

If you are the Injured Party and you completed the previous Section, you may skip Section 1.6 and proceed to Section 2.1.

If you are currently receiving the annuity payments, but you are not the originally Injured Party, please complete this Section.

What is the Current Payee's date of birth?

☐☐ – ☐☐ – ☐☐☐☐
MM DD YYYY

Is the Current Payee married or in a domestic partnership? ☐ Yes ☐ No

If *Yes*, please provide contact information for the spouse or domestic partner:

First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐ | Alternate Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

Does the Current Payee have children or other persons for whom the Current Payee is legally obligated to provide support? ☐ Yes ☐ No

What is the amount of this support on a yearly basis? **$** ☐☐☐☐☐☐ . ☐☐

If *Yes*, please provide names and contact information for each person. Attach additional sheets if necessary.

Person 1: First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐ | Alternate Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

Date of Birth (MM/DD/YYYY)

☐☐ – ☐☐ – ☐☐☐☐

What is the reason for the Current Payee's obligation to pay this person (court ordered obligation, third party obligation, etc.)? ______________________________

____

____

Person 2: First Name | MI | Last Name

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number ___ – ___ – ____

Alternate Phone Number ___ – ___ – ____

Date of Birth (MM-DD-YYYY) __ – __ – ____

What is the reason for the Current Payee's obligation to pay this person (court ordered obligation, third party obligation, etc.)? ______________________________

____

____

Section 2: **Current Condition**

If you are not claiming need or hardship based on the Injured Party's or Current Payee's medical condition, you may skip this Section and go to Section 3.1

Section 2.1: Current Condition

Please describe the current condition that is the basis for this claim of need. Please be clear as to whom the current condition affects (i.e. the Injured Party or Current Payee). You may attach additional sheets, if necessary.

____

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Has the person claiming need been determined to be "disabled" by the Social Security Administration, the Veteran's Administration or other similar federal or state agency? ☐ Yes ☐ No

If Yes, please explain. ______________________________

____

____

____

____

Do you anticipate future medical needs related to this condition? ☐ Yes ☐ No

If Yes, please explain. ______________________________

____

____

Does the person suffering from this condition have medical insurance? ☐ Yes ☐ No

If Yes, please provide the following:

Name of Insurance Company

Mailing Address, including unit or box number

City

State

Zip Code

Phone Number of Insurance Company

_ _ _ – _ _ _ – _ _ _ _

Policy number:

Name of the Insured:

First Name

MI

Last Name

Do you anticipate that any or all of the current and/or future medical needs related to this condition will be covered by medical insurance? ☐ Yes ☐ No

If No, please explain. ______________________________

____

____

Section 2.2: Treating Physician/Professional Information

Please provide the information below for each physician who is treating the medical conditions listed in Section 2.1.

Names and contact information of treating physician(s) or treating professional(s). Please complete the attached HIPAA waiver form for each treating professional and any facility that provides services, such as an assisted living facility, so that we may contact that person or facility in the event of questions.

Treating Physician/Professional 1

First Name MI Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including unit or box number

City State Zip Code

Email

Phone Number

– –

Treating Physician/Professional 2

First Name MI Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including unit or box number

City State Zip Code

Email

Phone Number

– –

Treating Physician/Professional 3

First Name | MI | Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including unit or box number

City | State | Zip Code

Email

Phone Number
– –

Ⓓ ***DOCUMENTATION:* Please provide any documents, such as doctors' reports, results of diagnostic tests or professional evaluations supporting the listed current condition, any report of a governmental determination of disability (workers' compensation, social security disability, etc.)**

Section 3: **Contact Information**

Section 3.1: Contact Information

Who should be contacted with questions?

First Name | MI | Last Name

Business Name and/or other Entity (if applicable)

Mailing Address, including apartment, unit or box number

City | State | Zip Code

Email

Phone Number
– –

Alternate Phone Number
– –

What is the relationship of this contact to the Injured Party or Current Payee? ______________________

Please use the following section to describe how the decrease in payments is causing or will cause a hardship. You may attach additional sheets, if necessary.

If you are determined to be eligible for a distribution from the ELNY Hardship Fund, please indicate whether you are interested in an annuity, lump sum or other form of payment: ☐ Annuity ☐ Lump Sum ☐ Other ____________

For help in completing this form,
call us toll-free **1-888-809-2254** or
email **questions@elnyhardshipfund.com**.

Part 4: **Certification**

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the answers and statements made in this Application are true and correct and all enclosures are true and correct copies.

_______________________________ _______________
Signature of Applicant *Date Signed*

_______________________________ _______________
Signature of Legal Representative or Guardian *Date Signed*

Reminder Checklist

Depending on your answers, **enclose these documents, if available:**

- A copy of the Settlement Agreement and annuity documents .... *page 3*
- A copy of the court order approving a transfer of rights to receive payments under the annuity .... page 3
- Documentation of the qualified assignment of the original settlement by a third party .... *page 3*
- A copy of a death certificate for a deceased applicant .... *page 4*
- A list of the Injured Party's/Current Payee's Assets and Liabilities .... *page 6*
- Income documentation .... *page 6*
    - W-2s or 1099
    - Last two (2) years' Federal tax returns
    - Court orders for alimony or child support
    - Federal and/or state payments
- Medical records, diagnostic testing, and/or any report of government determination of disability (workers' compensation, social security disability, etc.) .... *page 12*

Submit this Application form by September 15, 2012 to:
ELNY Hardship Fund Claims Administrator
PO Box 3207
Portland, OR 97208-3207

For help in completing this form,
call us toll-free **1-888-809-2254** or
email **questions@elnyhardshipfund.com**.

Part 5: **Release of the ELNY Hardship Fund from All Claims and Liability**

The ELNY Hardship Fund, Inc. (the "Fund") is a non-stock, not-for-profit corporation formed under New York law and voluntarily funded by [20] life insurance companies, all of which are members of the American Council of Life Insurers (the "Participating Companies") for the purpose of providing additional payouts to eligible ELNY payees who have been notified by the New York Liquidation Bureau that their contractual benefits will be reduced as a result of the court-ordered liquidation. Eligibility for, and the amount of payment received from, the Fund is at the sole discretion of the Fund.

As a condition of applying for benefits from the Fund, each applicant must sign the Release provided immediately below. Please note your application will not be considered without a signed Release. The purpose of the Release is to protect the Fund, Participating Companies and other entities from any claim regarding disposition of the Fund and determinations of payouts. There is no assurance that application to the Fund will result in voluntary payouts being provided to you by the Fund. Applicants may receive no payouts from the Fund, or receive less than the amount sought. The Fund has limited resources, and payouts will be determined by the management of an independent third-party administrator, JAMS, on behalf of the Fund, pursuant to guidelines established to evaluate the need of each applicant. These guidelines will be available on the website or by calling the Fund's Claim Administrator.

Terms of Release

For full and valuable consideration, including consideration of this application, I ________________________ (print name), on behalf of myself, my heirs, assigns, representatives and next of kin, do hereby irrevocably waive and release from any and all present and future claims of liability the entities set forth below, and each of its officers, officials, directors, agents, employees, sponsors, owners, affiliates, successors and assignees (as applicable):

The ELNY Hardship Fund, Inc.
JAMS, Inc.
The American Council of Life Insurers
The Participating Companies

This Release applies to all claims, demands, actions, or causes of action knowable and unknowable to me, that arise or may arise from the consideration of my application to the Fund, and to any and all determinations by the Fund, including but not limited to any decision regarding payouts. I acknowledge that all determinations by the Fund will be made exclusively by the Fund in its sole discretion. I further acknowledge that there is no appeal process or other mechanism to challenge any decision made by the Fund.

By: ____
(Signature)

____
(Print Name)

____
(Date)

Part 6: **Authorization for Release of Information (HIPAA)**

Patient Information:

_______________________________ _______________ _______________

PRINT name of patient | *Date of Birth* | *Social Security Number*

Information to be released from:

____

Name of Designated Facility or Provider

____

Address

_______________________________ (   ) _______________

City, State, Zip Code | *Phone Number*

Information to be released to:___________________________(and/or their authorized representatives or other person designated by them, including but not limited to attorneys, secretaries, paralegals, investigators, adjusters and doctors).

Representative: ____

Information to be released:

- ☐ All medical records (**Do not include films unless specifically requested**).
- ☐ Specific medical information (i.e., chart notes, labs, x-rays and special tests. **Please specify**): ______________________
- ☐ All employment records (i.e., payroll, educational, or job training. **Please specify**): ______________________
- ☐ All insurance records (i.e., applications, policies, payment records. **Please specify**):______________________
- ☐ All police records (i.e., reports, arrest records, jail/prison records, probation records. **Please specify**):

  ____

Purpose of Disclosure: ELNY Hardship Fund Application for funds

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
I understand that this consent includes the disclosure of: (PLEASE INITIAL):

______ Drug/Alcohol abuse/treatment & diagnosis

______ Sexually Transmitted Disease

______ HIV/AIDS diagnosis/treatment & testing

______ Mental Illness of Psychiatric diagnosis/treatment

I do hereby give my consent for release of any and all insurance records including applications, policies, payment records and the like. I also give my approval for release of any and all employment, payroll, educational, or job training records as may be deemed necessary by my legal representatives. As well, I approve the release of all police reports/records, arrest records, jail/prison records, and probation reports/records. This document covers information or material whose disclosure would, but for this waiver, be prohibited by state or federal statutes or regulations.

My Rights:

This authorization is pursuant to the Confidentiality of Medical Information Act of 1980. The person signing this authorization has a right to receive a copy hereof, and a reproduced copy of this authorization shall be as valid as the original. This authorization is in force from the date of signature herein due to the nature, duration, and extent of this case. This authorization applies to all records both prior to, and after the date of signature. I understand this consent may be revoked in writing at any time. With the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 365 days from the date of signing. To initiate revocation of this authorization direct all correspondence to the "Designated Recipient" above. I understand that the information used or disclosed may be subject to re-disclosure by the persons or class of persons receiving it and no longer protected by the federal privacy regulations. **Patient's care will not be affected or conditioned by signing this authorization.**

SIGNATURE: _______________________________________ **DATE:** ______________

(Patient, Guardian*, or Authorized Representative*)

*** Please provide documents to prove authority to sign on behalf of patient.**