CASE ANALYSIS

Client _____ Date of Consultation _____

DOI: _____ P.D. $ _____ Police Rpt? Yes No Def.Ins.Co _____

Police Dept:_____ Rpt # _____ Officer _____

P.D. Address _____ P.D. City,, State, Zip _____

Police Report Supplied? Yes No Time of Accident _____ AM PM

Client's Insurance Information

Your Car Insurance Company:_____

Address:_____ Phone # _____

Policy # _____ In Force? Yes No Claim # _____

P.D. Adjustor:_____ Phone # _____ Fax # _____

B.I. Adjustor: _____ Phone # _____ Fax # _____

Your Health Insurance Company _____

Health Ins. Policy # _____ Phone _____

OTHER DRIVER (DEFENDANT/PERSON WHO HIT YOUR CAR)

Name _____ Driver License # _____ State _____

Admitted Liability? _____ Statute? _____ Arrested? Yes No Fault in Police Rpt? Yes No

Address _____ City _____Zip _____

Cell Phone _____ Home Phone _____

In Company Vehicle? Yes No Vicarious Liability? Yes No

Employer _____ Work Phone _____

Work Address _____ City, State, Zip _____

DL # _____ State _____ Make _____ Model _____ License _____

Driver's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

Registered Owner's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

2nd OTHER DRIVER (2nd PERSON IN ACCIDENT)

Name _____ Driver License # _____ State _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

Make of Vehicle _____ Model _____ License Plate _____

2nd Driver's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

2nd Car Registered Owner's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

3rd OTHER DRIVER (3rd PERSON IN ACCIDENT)

Name _____ Driver License # _____ State _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

Make of Vehicle _____ Model _____ License Plate _____

3rd Driver's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

3rd Car's Registered Owner's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

P.D. Adjustor's Name _____ Phone # _____ Fax # _____

B.I. Adjustor's Name _____ Phone # _____ Fax # _____

U.M. $_____ Med Pay $ _____ Collision? Yes No Car Rental? Yes No

If there were any PASSENGERS in your car, please give us this information

Passenger #1_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

Passenger #2_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

Was there a WITNESS?

Name _____ DL # _____ Phone # _____

Address _____City _____, State ____ Zip _____

Vehicle witness was in? _____ License Plate _____ State _____

	Received	Will Send	Doesn't Have	Doesn't Exist
Police Report	( )	( )	( )	( )
Driver's License Color Copy	( )	( )	( )	( )
Client's Ins. Dec. Page	( )	( )	( )	( )
Letters from Client's Ins. Co	( )	( )	( )	( )
Letters from Def's Ins. Co.	( )	( )	( )	( )
Letters from 2nd, 3rd Ins. Co.	( )	( )	( )	( )
Repair Estimate	( )	( )	( )	( )
Pictures of Client's Car Damage	( )	( )	( )	( )
Pictures of Def's Car Damage	( )	( )	( )	( )
Picture of Client's Injuries	( )	( )	( )	( )
Medical Bills	( )	( )	( )	( )
Copy of Health Insurance Card	( )	( )	( )	( )
Rental Car Bill	( )	( )	( )	( )
Towing Bill	( )	( )	( )	( )
LOE Letter from Employer	( )	( )	( )	( )
Personal Prop. Documentation	( )	( )	( )	( )
Color Copy of Driver License	( )	( )	( )	( )

Client Background

Military Service? _____

_____

Scouts? _____

High School Awards/Clubs? _____

College Awards/Clubs? _____

Civic Groups Memberships? _____

Volunteer for Any Groups? _____

Mentor? _____

Work _____

_____

Family/Children? _____

_____

PTA? _____

Church? _____

Hobbies? _____

_____

_____

Athletics/Sports? _____

_____

_____

Facebook? _____

Twitter? _____

My Space? _____

Other Social Networking Sites? _____

Steven C Eggleston, Esq.
Attorney at Law
2601 Main Street, Suite 800
Irvine, California 92614
Voice (877) 424-4765 - Fax (877) 883-2963
Dr.Eggleston@yahoo.com

DESIGNATION TO HANDLE THIRD PARTY CLAIM

TO: _____

DATE OF INCIDENT: _____

CLAIM NUMBER: _____

Pursuant to Section 2695.2(c) of the California Code of Regulations, Title 10, chapter 5, and California Insurance Code I authorize STEVEN C EGGLESTON, my attorney, to handle my personal injury and property damage claim under the above captioned loss.

This authorization shall be valid for only three years from the below date unless renewed or revoked by the undersigned. Any and all prior authorizations are hereby revoked by the undersigned as of the date of this authorization. A copy, photocopy, or facsimile of this signed Authorization shall be as effective and valid as the original.

_____ _____
Signature of Client (or Client's Legal Representative if a Minor) Date

_____
Print Name of Signatory

_____
(Legal Relationship of Signatory if not Client)

_____
Street Address

_____
City, State, Zip

Steven C Eggleston, Esq.

Attorney at Law
2601 Main Street, Suite 800
Irvine, California 92614
Voice (877) 424-4765 - Fax (877) 883-2963
Dr.Eggleston@yahoo.com

DESIGNATION TO HANDLE FIRST PARTY PIP and UM CLAIMS

TO: _____

DATE OF INCIDENT: _____

CLAIM NUMBER: _____

Pursuant to Section 2695.2(c) of the California Code of Regulations, Title 10, chapter 5, and California Insurance Code Section 11580.2, I authorize STEVEN C EGGLESTON, my attorney, to handle my first party PIP and UM personal injury and property damage claim under the above captioned loss.

This authorization shall be valid for only three years from the below date unless renewed or revoked by the undersigned. Any and all prior authorizations are hereby revoked by the undersigned as of the date of this authorization. A copy, photocopy, or facsimile of this signed Designation shall be as effective and valid as the original.

I declare under penalty of perjury that ( ) I do ( ) I do NOT have a workers' compensation claim associated with this date of accident and the subject matter of this uninsured/underinsured motorist claim.

_____ _____
Signature of Client (or Client's Legal Representative if a Minor) Date

_____
Print Name of Signatory

_____
(Legal Relationship of Signatory if not Client)

_____
Street Address

_____
City, State, Ziip

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____
Date of Birth _____ SS# _____
I authorize the release of Health Information to:

Steven C Eggleston, D.C.
Doctor of Chiropractic
2601 Main Street, Suite 800
Irvine, California 92614
(877) 424-4765 Fax (877) 883-2963
Email to: Dr.Eggleston@yahoo.com

INFORMATION TO BE RELEASED

_____ Complete Medical Record Including Billing Statement and Reports

_____ Billing Statements
_____ Laboratory Reports
_____ Dental Records
_____ Pathology Reports/Records
_____ Diagnostic Imaging Reports
_____ Discharge Summary
_____ Emergency Medicine Reports/Records
_____ History & Physical Exam Reports/Records
_____ Operative Reports/Records
_____ Diagnostic Imaging Films

SPECIFIC AUTHORIZATIONS

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment (42 C.F.R. §§ 2.34 and 2.35)
_____ I specifically authorize the release of information pertaining to mental health or psychiatric diagnosis or treatment (Welfare and Institutions Code §§ 5328, *et seq.*)
_____ I specifically authorize the release of HIV/AIDS testing information (Health and Safety Code § 120980(g))
_____ I specifically authorize the release of genetic testing information (Health and Safety Code § 124980(j))

THE PURPOST OF THIS RELEASE IS (check one or more)

_____ Continuity of care or discharge planning
_____ Billing and payment of bill
_____ At the request of the patient/patient's representative
_____ Review of records
_____ Other (state reason) _____

NOTICE

Health Care Providers and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep health information confidential. If you have authorized the disclosure of your health information to someone who is not

legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: (1) conducting research-related treatment; (2) obtaining information in connection with eligibility or enrollment in a health; (3) for determining an entity's obligation to pay a claim; or (4) creating health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

I may revoke this authorization at any time, provided that I do so in writing and submit it to: STEVEN C EGGLESTON, D.C. The revocation will take effect when received by STEVEN C EGGLESTON, D.C., except to the extent that STEVEN C EGGLESTON, D.C. or other have already relied on it.

I am entitled to received a copy of this Authorization

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____ *(insert applicable date or event). If not date is indicated, this authorization will expire 12 months after the date of signing this form.*

SIGNATURE

It is my intent that a copy, photocopy or facsimile copy of this Authorization for Release of Health Information shall be as valid as an original copy.

_____ _____
(Signature of Patient or Patient's Legal Representative) Date

_____ _____ AM PM
Printed Name Time

_____
(Legal Relationship of Signatory if not Patient)

_____
Signature of Witness or Translator

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

Name of Health Care Provider

Name of Medical Office/Hospital

Street Address

City, State **and Zip** Code

Please **SEND** Medical Information TO:

Name of Person or Entity to Receive Information

Title (Physician, Therapist, Attorney)

Street Address

City, Slate and Zip Code

I hereby authorize _____ **to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.**

Release and / or disclose records and information regarding: Date of Injury: _____

Name of Patent (List Other Names Used) | Medical Record Number | Date of Birth

Address | City | State Zip Code | ( ) Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ *(enter date)* or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDIS-CLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED: Check the box and initial which type of information is to be released and / or disclosed:

- ☐ General Medical Information *(from* _____ *to* _____)
- ☐ Information Regarding Specific Injury or Treatment *(from* _____ *to* _____)
- ☐ X-Ray (check one or both): ☐ Films ☐ Reports
- ☐ Laboratory Results
- ☐ Mental Health *(from* _____ *to* _____)
- ☐ Alcohol / Drug *(from* _____ *to* _____)
- ☐ HIV Test Results *(from* _____ *to* _____)
- ☐ Other (specify): Billing Records

Signature of Patient or Patient's Representative — Date

Signature of Patient or Patient's Representative — Date

Signature of Patient or Patient's Representative — Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

Date | Signature of Patient or Patient's Representative | Indicate Relationship (if Signed by Other than Patient)

Steven C Eggleston, Esq.

2601 Main Street, Suite 800
Irvine, California 92614
Voice (877) 424-4765 - Fax (877) 883-2963

AUTHORIZATION

TO: _____ DATE OF ACCIDENT: _____

DESCRIPTION/LOCATION:_____

I/We hereby authorize my/our attorney, Steven C Eggleston, or his representative, to receive, inspect, examine, reproduce or copy in any manner, and obtain oral and written reports thereon as he may request, any of the following:

1. Any and all of my hospital records, x-ray films and reports, laboratory reports and records, diagnostic imaging films and reports, statement of charges and/or professional fees, and any and all records pertaining to my hospital visit or stay;
2. Any and all medical records from any type of health care provider including, but not limited to, holders of degrees such as MD, DC, DO, OD, DDS, DMD, L.Ac., CMT, PT, RN, LVN, Ambulance Company, etc. and will include my patient records, x-rays films and reports, lab reports, diagnostic tests of any kind, any and all types of diagnostic imaging films and reports, statements of charges and/or professional fees, and any and all records pertaining to my health care;
3. Any and all employment records, including time cards, payroll, vacation and sick leave records;
4. Any and all records and reports from any government agency including, but not limited to, Police, Sheriff, Highway Patrol, coroner, peace officer, DMV, Medicare, Medicaid, MediCal, Veterans Administration, or any other law enforcement or government entity that may pertain to my accident/injury;
5. Any and all legal records and files from prior accidents and/or injuries including, but not limited to, workers compensation claims, personal injury claims, or any other injury to my person that may pertain to my current accident/injury and my complete legal file; or
6. Any and all records, reports, files and information from my personal health insurance company, HMO, automobile insurance company, or any other health insuring entity that I have used in the past or am currently using.

You are further requested to not disclose any information to any insurance adjuster or other person without written authority from me to do so (pursuant to privilege and confidential information statutes). ALL PRIOR AUTHORIZATIONS ARE HEREBY REVOKED AND CANCELLED.

A copy, photocopy, or facsimile of this signed Authorization shall be as effective and valid as the original. This Authorization is valid for five (5) years from the date signed.

_____ _____
Signature of Client or Client's Legal Representative Date

_____ _____
Printed Name (Legal Relationship of Signatory)

Steven C Eggleston, Esq.
2601 Main Street, Suite 800
Irvine, California 92614

Voice (877) 424-4765
Fax (877) 883-2963
Email: Dr.Eggleston@yahoo.com

ATTORNEY-CLIENT CONTINGENT FEE CONTRACT

This ATTORNEY-CLIENT CONTINGENT FEE CONTRACT (the "Agreement") is the written fee contract that California law requires lawyers to have with their clients. _____, the Client(s), herein contract(s) with STEVEN C EGGLESTON, ESQ. ("Attorney")

1. CONDITIONS. This Agreement will not take effect, and Attorney will have no obligation to provide legal services, until Client and Attorney have both signed this Agreement.

2. SCOPE OF SERVICES. Client is hiring Attorney to represent Client in the matter of Client's claim arising out of _____, which occurred on or about _____ _____. Attorney will provide those legal services reasonably required to represent Client, and will take reasonable steps to inform Client of progress and to respond to Client's inquiries. If a court action is filed, Attorney will represent Client until a settlement or judgment, by way of arbitration or trial, is reached, including opposing or making appropriate post-trial motions. After judgment, Attorney will not represent Client on any appeal, or in any proceedings designed to execute on the judgment, without such additional compensation as Attorney and Client may agree upon in a separate Agreement. Attorney complies with the State Bar of California requirement of maintaining statutory limits of professional errors and omissions insurance.

3. CLIENT'S DUTIES. Client agrees to be truthful with Attorney, to cooperate, to keep Attorney informed of developments, to abide by this Agreement, and to keep Attorney informed of Client's address, telephone number, and whereabouts.

4. LEGAL FEES AND HANDLING OF CLIENT FUNDS. Attorney will only be compensated for legal services rendered if Client obtains a recovery in the matter described in Section 2. Should Client discharge Attorney pursuant to Section 8, Attorney shall be entitled to a reasonable fee for the legal services provided by Attorney to Client and such fee shall become payable when Client obtains a recovery in the matter. The Client and Attorney agree that fees shall be 33 1/3% of the gross recovery if this matter is settled prior to the initiation of litigation. Should the Attorney deem it necessary to file a lawsuit or, as in an uninsured or underinsured motorist case, a written demand for arbitration is presented, then Attorney's fees shall be 40% of the gross recovery.

Attorney may, at his sole discretion, consult with or enlist the services of other attorneys, including, but not limited to the law firm of Callahan, Thompson, Sherman & Caudill, LLP (hereinafter referred to as "CTSC") for joint handling of this matter. By signing this Agreement, Client consents in advance to the association of CTSC or other attorneys into this matter, that Attorney will share a portion of the attorney fee with the other law firm(s), that such an even will *not increase* Attorney's fee listed in Section 4, paragraph 1, that such association may include all aspects of representation of the Client's interests through trial and that the sharing of the attorney fee will be based on the amount of work each attorney performs.

Prior to the Client's approval of a settlement, and before any disbursements of any recovery or funds, Client will receive a statement itemizing the gross recovery, deductions for Attorney's fee, costs, and outstanding medical balance(s) or lien(s) to be satisfied out of the recovery, other deductions to which the Client agrees or has become obligated, and the net amount to be received by the Client. The

proceeds from the settlement or judgment will be deposited into Attorney's Client Trust Account and all funds will be disbursed from that account.

In the event that Attorney enlists the services of CTSC on this case, Attorney will *divide* the 33 1/3% attorney fees listed in Section 4, paragraph 1, (or 40% if only if the case goes into litigation) with CTSC. This means that the attorney fees will *not* change at all for the Client (only that Attorney may share some of the legal fees with other attorneys that assist him with the case.) Client is informed that, under the Rules of Professional Conduct of the State Bar of California, such a division may be made only with the Client's written consent after a full disclosure to the Client has been made in writing including the terms of such division. The terms of the sharing of the 33 1/3% (or 40% if the case goes into litigation) are described as follows (with the understanding that the *Client's* portion of the settlement that goes to the *total* attorney fees will not change even though it is being *shared* with another attorney.): (a) 40% of attorney fees will be shared if the case resolves prior to litigation; (b) 50% of attorney fees will be shared if the case settles within 180 days of filing a lawsuit against a third party; (c) 60% of attorney fees will be shared if the case settles after 180 days of filing a lawsuit but before the end of the Mandatory Settlement Conference; (d) 65% of attorney fees will be shared if the case settles after the Mandatory Settlement Conference or is resolved by jury verdict.

5. PROPERTY DAMAGE SETTLEMENT AND/OR TOTAL LOSS SETTLEMENT. Attorney may set up an Ethical Wall (information barrier) between client's insurance company and tortfeasor's insurance company in regard to property damage settlement in order to separate and isolate persons who may otherwise share information about this accident that may be detrimental to client's interest. This is a way of avoiding conflict of interest problems between client's insurance adjuster and tortfeasor's insurance adjuster. Attorney may require that all communication between insurance companies pass through attorney's office for review. Attorney may be compensated for this service via the subrogation process between insurance companies. Client shall *not* be responsible to pay attorney separately for this service.

6. NEGOTIABILITY OF FEES. Attorney fees are not set by law, but are agreed upon between Client and Attorney.

7. COSTS AND EXPENSES. Attorney and/or CTSC may advance costs to pay for things such as court filing fees, service of process, mediation expenses, deposition costs, and arbitration fees. Attorney and CTSC are entitled to reimbursement of expenses for which a check has been written or a receipt exists showing the expense has been paid on behalf of Client. Costs advanced by Attorney and/or CTSC on Client's behalf will be deducted from the Client's portion of the recovery. Costs of litigation and trial are the responsibility of the Client and Client shall advance those costs. Client will not be itemized for pre-litigation photocopying, postage, overnight deliveries, shipping, facsimile and other miscellaneous office expenses for which attorney has no receipt. In lieu of iteming, these services will be capped at a maximum of $150 flat fee which will be charged to the client for all pre-litigation photocopying, postage, overnight deliveries, shipping, facsimile, and other miscellaneous office expenses. Post litigation photocopying, postage, overnight deliveries, shipping, facsimile, and other miscellaneous office expenses will be itemized and billed to the Client and paid by the Client at the time of the settlement disbursement.

8. DISCHARGE AND WITHDRAWAL. Client may discharge Attorney at any time, upon written notice to Attorney, and Attorney will immediately after receiving such notice, cease to render additional services. Such a discharge does not, however, relieve Client of the obligation to pay any costs incurred prior to such termination, and Attorney and CTSC have the right to recover from Client the reasonable value of Attorney's legal services rendered from the effective date of this Agreement to the date of discharge. Attorney and CTSC may withdraw from representation of Client: (a) with

Client's consent; (b) upon court approval; or (c) if no court action has been filed, upon reasonable notice to Client.

9. LIEN. Client hereby grants Attorney and CTSC a lien on any and all claims or causes of action that are the subject of Attorney's representation under this Agreement. Attorney's lien will be for any sums owing to Attorney for any unpaid costs and attorney fees under this Agreement. The lien will attach to any recovery Client may obtain, whether by arbitration award, judgment, settlement, or otherwise.

10. CONCLUSION OF SERVICES. Attorney's services conclude upon disbursement of funds to Client or pursuant to Section 8 of this Agreement. Attorney will, upon Client's request, deliver Client's file to Client. Otherwise, Attorney will retain file for five (5) years after which it will be destroyed without further notice to Client.

11. DISCLAIMER OF GUARANTEE. Nothing in this Agreement and nothing in Attorney's statements to Client will be construed as a promise or guarantee about the outcome of Client's matter. Attorney makes no such promises or guarantees. There can be no assurance that Client will recover any sum or sums in this matter. Attorney comments about the outcome of Client's matter are expressions of opinion only.

12. MANDATORY BINDING ARBITRATION. In any controversy or claim arising out of or relating to this Agreement, or the breach thereof, the dispute will be submitted for binding arbitration to a retired California Superior Court Judge and Attorney and Client will be bound by the result. Client understands and acknowledges that, by agreeing to binding arbitration, Client waives the right to submit the dispute for determination by a court and hereby also waives the right to a jury or bench trial.

I/We have read and understand the foregoing terms and agree to them, as of the date that Attorney first provided services. If more than one party signs below, we agree to be liable jointly and severally for all obligations under this Agreement. By signing this Agreement, I/We acknowledge receipt of a fully executed duplicate of this Agreement.

Arbitration Notice to Client: By signing this Agreement, Client(s) agree to have issues including malpractice decided by binding arbitration and Client acknowledges that Client is giving up Client's right to a jury or bench trial for such disputes.

Date	Signature of Client or Client's Legal Representative	(Legal Relationship to Signatory)
Date	Signature of Client or Client's Legal Representative	(Legal Relationship to Signatory)
Date	Attorney's Signature Here Denotes Acceptance of Case	

LIMITED AUTHORIZATION TO RELEASE EMPLOYMENT RECORDS

Name _____ Date of Injury _____

SS # _____ Date of Birth _____

Ins. Co. _____ Ins. Claim # _____

Expiration of Authorization _____

Scope of Authorization: From _____ to present ONLY. THIS AUTHORIZATION IS EXPRESSLY LIMITED TO THESE DATES ONLY AND YOU ARE NOT AURHOTIZED TO DISCLOSE MY EMPLOYMENT INFORMATION PRIOR TO THE DATE LISTED. I authorize any employer to disclose information contained in my personal employment records for the limited dates listed above. I specifically authorize wage information such as salary per month or hourly wages and average number of hours worked per month, and timing of employment (dates for commencement and cessation of employment).

I authorize the use of the above information to permit the listed insurance company to investigate, process, and determine the amount payable for all claims made under any property and casualty insurance policy that applies to the accident or occurrence on the date listed above. **THIS INFORMATION MAY <u>NOT</u> BE RELEASED IN ANY MANNER OR FORM BY THE NAMED INSURANCE COMPANY TO ANY OTHER INSURANCE COMPANY FOR ANY PURPOSE WHATSOEVER, INCLUDING DISSEMINATION TO ANY MEDICAL INDEX BUREAUS (BY ANY NAME) WHICH COLLECT, STORE, AND FURNISH EMPLOYMENT INFORMATION TO OTHER INSURANCE COMPANIES.** This information is for the sole and exclusive use of THIS INSURANCE COMPANY in the handling of this claim arising from the motor vehicle collision that occurred on the date listed above.

I have worked for the following employers during the past five (5) years:

Company _____ from _____ to _____

Address _____ Phone _____

Supervisor _____ ID# _____

Company _____ from _____ to _____

Address _____ Phone _____

Supervisor _____ ID# _____

Company _____ from _____ to _____

Address _____ Phone _____

Supervisor _____ ID# _____

Company _____ from _____ to _____

Address _____ Phone _____

Supervisor _____ ID# _____

A photocopy of this authorization is as valid as the original. I have read this authorization and signed this document as a free and voluntary act for the purposes noted above.

_____ _____

Signature of Employee (or Employee's Legal Representative) Date

_____

Print Name

_____

(Legal Relationship of Signatory if not Employee)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? ☐ Yes	☐ No.
If yes, please complete the following. If no, proceed to Section II.	
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*	
Medicare Claim Number (no dashes)	Date of Birth (Mo/Day/Year) - -
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	Sex ☐Female ☐ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ Claim Number _____

Name of Person Completing This Form If Claimant is Unable (Please Print) _____

Signature of Person Completing This Form _____ Date _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____ _____

Claimant Name (Please Print) Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form Date

POWER OF ATTORNEY TO ENDORSE SETTLEMENT CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Steven C Eggleston, attorney at law, to be the undersigned's true and lawful Attorney for and in the undersigned's name, place and stead to endorse any and all checks or drafts from any insurance company which are made payable to the undersigned alone or to the undersigned and Steven C Eggleston, attorney at law, or the Law Offices of Steven C Eggleston, which checks or drafts are settlements in connection with undersigned's personal injury which occurred on _____.

The undersigned by these presents does thus give and grant unto Steven C Eggleston, attorney at law, as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and depositing of said checks are concerned. The undersigned specifically appoints and authorizes Steven C Eggleston, attorney at law, 2601 Main St., Suite 800, Irvine, CA 92614, to endorse on my behalf check number _____, dated _____, from _____ insurance company. The endorsement is to be for deposit only into Steven C Eggleston's Attorney-Client Trust Account from which my settlement funds will be disbursed. This document may be executed by facsimile and email and a copy is deemed to be as valid as an original. I hereby grant to Steven C Eggleston, attorney at law, authority to execute all documents to complete and finalize the settlement and distribution of my settlement. It is my intent that a copy, photocopy or facsimile copy of this Power of Attorney To Endorse Settlement Checks shall be as effective and valid as the original.

_____ _____

Signature of Client Granting Power of Atty Date Signed

_____ _____

Client's Full Name (Printed) Person Witnessing Signature