



# CONCUSSION SETTLEMENT

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

## **SUPPLEMENTAL CLAIM PACKAGE FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**YOU MUST HAVE BEEN PAID ON AN EARLIER MONETARY AWARD BEFORE  
YOU SUBMIT A SUPPLEMENTAL CLAIM PACKAGE**

This Supplemental Claim Package contains:

1. The Supplemental Claim Form and Supplemental Claim Form Instructions Booklet; and
2. MAF Diagnosing Physician Certification Form.

Follow the instructions for each document and fill out all of the fields to the best of your knowledge.

You also must submit medical records that reflect your new Qualifying Diagnosis.

**If you have any questions or need any help completing your Supplemental Claim Package:**

**Call 1-855-887-3485**

**Email [ClaimsAdministrator@NFLConcussionSettlement.com](mailto:ClaimsAdministrator@NFLConcussionSettlement.com)**

**Visit [www.NFLConcussionSettlement.com](http://www.NFLConcussionSettlement.com)**



# CONCUSSION SETTLEMENT

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

## INSTRUCTIONS FOR COMPLETING THE NFL CONCUSSION SETTLEMENT SUPPLEMENTAL CLAIM FORM

| TABLE OF CONTENTS |                                                        |      |
|-------------------|--------------------------------------------------------|------|
|                   | TITLE                                                  | PAGE |
| 1.                | How to Fill Out the Supplemental Claim Form            | 3    |
| 2.                | How to Submit the Supplemental Claim Form              | 12   |
| 3.                | How to Ask Questions About the Supplemental Claim Form | 12   |
| 4.                | Useful Settlement Agreement Definitions                | 13   |

## 1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM

### GENERAL INSTRUCTIONS

These instructions will take you step-by-step through the hard copy Supplemental Claim Form. It may be easier to complete this form online, which you can do by visiting the NFL Concussion Settlement website at [www.nflconcussionsettlement.com](http://www.nflconcussionsettlement.com) and following the instructions there. If you are represented by counsel, consult with your lawyer about your responses to this Supplemental Claim Form and the requirements for a complete Claim Package.

Complete this Supplemental Claim Form only 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. Do not use this Supplemental Claim Form if: (1) you have not previously received a Monetary Award, or (2) you are a **Derivative Claimant** of a Retired NFL Football Player and want to submit a Derivative Claimant Claim Package. There are separate Claim Forms for Monetary Awards and Derivative Claimants available on the NFL Concussion Settlement website.

Type all responses or print clearly in blue or black ink. If there is not enough space for your responses, make a copy of the applicable page, add the additional information and attach it to the completed Supplemental Claim Form. The capitalized terms in this form are defined in the Settlement Agreement, which is available at <https://nflconcussionsettlement.com/Documents.aspx> or by calling toll free 1-855-887-3485. For your convenience, there also is a glossary of select terms included at the end of these instructions.

Your Supplemental Claim Package must include:

1. This Supplemental Claim Form;
2. A Diagnosing Physician Certification Form (available on the NFL Concussion Settlement website) signed by the Qualified MAF Physician or Qualified BAP Provider who made a new Qualifying Diagnosis that is **different from** and **occurred after** the Qualifying Diagnosis for which you previously received a Monetary Award; and
3. All medical records created by or received from the Qualified MAF Physician or Qualified BAP Provider in connection with your new Qualifying Diagnosis.

You do not have to submit a new HIPAA Form or any proof of NFL Employment. **Your Claim Package must be submitted to the Claims Administrator no later than two years after the date that you received your new Qualifying Diagnosis. Failure to meet this deadline will preclude you from receiving a Supplemental Monetary Award for that new Qualifying Diagnosis unless you can: (1) show substantial hardship (beyond the Qualifying Diagnosis) that prevented your compliance; and (2) submit the Claim Package within two years of the missed deadline.**

If your claim is selected for audit, you may be required to submit additional records or information now or in the future. You are required to preserve all such additional records in your possession, custody or control and to instruct your health care providers to preserve such records that may be requested under Section 10.3(e) of the Settlement Agreement. These documents include but are not limited to historical medical records related to the underlying medical condition that is the basis for the claimed Qualifying Diagnosis. Unreasonable failure to preserve and provide all records and information requested by the Claims Administrator in connection with an audit within the time frame specified will result in the claim being denied without the right to an appeal.

**1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM****I. RETIRED NFL FOOTBALL PLAYER INFORMATION**

Enter the Retired NFL Football Player's information in Section I.

|    | <b>Name of Field</b>                                                                           | <b>Instructions</b>                                                                                                                                                                                                                                                                |
|----|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | <b>Settlement Program ID</b>                                                                   | Enter the Retired NFL Football Player's nine-digit Settlement Program ID. You can find it in Section I of the Notice of Registration Determination.                                                                                                                                |
| 2. | <b>Player Name</b>                                                                             | Enter the Retired NFL Football Player's first name, middle initial, last name and suffix (if applicable).                                                                                                                                                                          |
| 3. | <b>Player Date of Birth</b>                                                                    | Enter the Retired NFL Football Player's date of birth in this format: MM/DD/YYYY.                                                                                                                                                                                                  |
| 4. | <b>Player Date of Death (if applicable)</b>                                                    | Enter the Retired NFL Football Player's date of death, if applicable, in this format: MM/DD/YYYY.                                                                                                                                                                                  |
| 5. | <b>Player Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen)</b> | Enter the Retired NFL Football Player's Social Security, Taxpayer ID or Foreign ID number if he is/was not a U.S. citizen.                                                                                                                                                         |
| 6. | <b>Player Mailing Address</b>                                                                  | Enter the Retired NFL Football Player's mailing address as follows: (a) street address or P.O. box number in "Address 1"; (b) unit, suite, or apartment number in "Address 2"; (c) city; (d) state or province (if in a foreign country); (e) zip or postal code; and (f) country. |
| 7. | <b>Player Telephone</b>                                                                        | Enter the Retired NFL Football Player's area code and telephone number.                                                                                                                                                                                                            |
| 8. | <b>Player Email Address</b>                                                                    | Enter the Retired NFL Football Player's email address.                                                                                                                                                                                                                             |

**II. REPRESENTATIVE CLAIMANT INFORMATION**

If you are the Representative Claimant of a Retired NFL Football Player who is deceased, or legally incapacitated or incompetent, enter your information in Section II. Do not complete Section II if you are a Retired NFL Football Player and provided your information in Section I. If you are a Representative Claimant for a Retired NFL Football Player who died or became legally incapacitated or incompetent after he received payment on his prior award, you must inform us of the change and must be substituted as his representative to pursue any Supplemental Monetary Award in the Program.

|     | <b>Name of Field</b>                                                                                   | <b>Instructions</b>                                                                                          |
|-----|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| 9.  | <b>Representative Name</b>                                                                             | Enter the Representative Claimant's first name, middle initial, last name and suffix (if applicable).        |
| 10. | <b>Representative Date of Birth</b>                                                                    | Enter the Representative Claimant's date of birth in this format: MM/DD/YYYY.                                |
| 11. | <b>Representative Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen)</b> | Enter the Representative Claimant's Social Security, Taxpayer ID or Foreign ID number if not a U.S. Citizen. |

**1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM**

|     |                                       |                                                                                                                                                                                                                                                                                |
|-----|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12. | <b>Representative Mailing Address</b> | Enter the Representative Claimant's mailing address as follows: (a) street address or P.O. box number in "Address 1"; (b) unit, suite, or apartment number in "Address 2"; (c) city; (d) state or province (if in a foreign country); (e) zip or postal code; and (f) country. |
| 13. | <b>Representative Telephone</b>       | Enter the Representative Claimant's area code and telephone number.                                                                                                                                                                                                            |
| 14. | <b>Representative Email Address</b>   | Enter the Representative Claimant's email address.                                                                                                                                                                                                                             |

**III. LAWYER INFORMATION**

If you are represented by a lawyer, enter that lawyer's information in Section III. We will direct all future communications about this claim to the designated lawyer. If you do not have your own lawyer, you should skip this section and go to Section IV.

|     |                               |                                                                                                                                                                                                                                                            |
|-----|-------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 15. | <b>Lawyer Name</b>            | Enter the lawyer's first name, middle initial, last name and suffix (if applicable).                                                                                                                                                                       |
| 16. | <b>Law Firm Name</b>          | Enter the name of the lawyer's firm.                                                                                                                                                                                                                       |
| 17. | <b>Lawyer Mailing Address</b> | Enter the lawyer's mailing address as follows: (a) street address or P.O. box number in "Address 1"; (b) unit, suite, or office number in "Address 2"; (c) city; (d) state or province (if in a foreign country); (e) zip or postal code; and (f) country. |
| 18. | <b>Lawyer Telephone</b>       | Enter the lawyer's area code and telephone number.                                                                                                                                                                                                         |
| 19. | <b>Lawyer Email Address</b>   | Enter the lawyer's email address.                                                                                                                                                                                                                          |

**IV. QUALIFYING DIAGNOSIS/ES**

|     |                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20. | <b>Qualifying Diagnosis/es Information</b> | Check the applicable Qualifying Diagnosis and enter the date of diagnosis using this format: MM/DD/YYYY. Enter the state in which the Retired NFL Football Player was domiciled, <i>i.e.</i> lived, at the time of the new Qualifying Diagnosis. Identify the Qualified MAF Physician or Qualified BAP Provider who diagnosed the condition and enter his or her first name, middle initial, last name and suffix (if applicable). If the Retired NFL Football Player was diagnosed with Level 2 Neurocognitive Impairment in the Baseline Assessment Program ("BAP"), provide the name of both the diagnosing neuropsychologist and the diagnosing board-certified neurologist. |
|-----|--------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## 1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM

### V. ADDITIONAL MEDICAL INFORMATION

Section V addresses whether the Retired NFL Football Player suffered a Stroke or Traumatic Brain Injury **before** his Qualifying Diagnosis. Check the appropriate box for each injury. If the Retired NFL Football Player was diagnosed with more than one Stroke or Traumatic Brain Injury before the Qualifying Diagnosis, copy page 5, provide the additional information and attach it to the completed Claim Form.

#### V.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 NO if the Retired NFL Football Player has not had a Stroke after the Qualifying Diagnosis on which the Player was paid an award. Check YES if the Retired NFL Football Player has had a Stroke after the Qualifying Diagnosis on which the Player was paid an award and provide information on the Stroke.

|     |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 21. | <b>Date of Stroke Diagnosis</b>                          | Enter the date of the Stroke using this format: MM/DD/YYYY.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 22. | <b>Medical professional who diagnosed the Stroke</b>     | Identify the medical professional who diagnosed the Stroke. Enter his or her first name, middle initial, last name and suffix (if applicable).                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 23. | <b>Causal Relation of Stroke to Qualifying Diagnosis</b> | Check this box if you answered YES, but believe the Stroke was not causally related to the Qualifying Diagnosis for which you are claiming a Supplemental Monetary Award. You must also submit medical records and other evidence supporting this assertion. If these records establish by clear and convincing evidence that the Stroke is not causally related to the Qualifying Diagnosis, no Offset will apply. If we have information regarding a Stroke but you do not check this box, we will have to apply the Offset and reduce any Supplemental Monetary Award by 75%. |

## 1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM

### V.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 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. Check YES if the Retired NFL Football Player has had a severe traumatic brain injury after the Qualifying Diagnosis on which the Player was paid an award, and provide information about the severe traumatic brain injury.

|     |                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 24. | <b>Date of Traumatic Brain Injury</b>                                    | Enter the date of the Traumatic Brain Injury using this format: MM/DD/YYYY.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 25. | <b>Medical professional who diagnosed the Traumatic Brain Injury</b>     | Identify the medical professional who diagnosed the Traumatic Brain Injury. Enter his or her first name, middle initial, last name and suffix (if applicable).                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 26. | <b>Causal Relation of Traumatic Brain Injury to Qualifying Diagnosis</b> | Check this box if you answered YES, but believe that the traumatic brain injury was not causally related to the Qualifying Diagnosis for which you are claiming a Supplemental Monetary Award. You must also submit medical records and other evidence supporting this assertion. If these records establish by clear and convincing evidence that the traumatic brain injury is not causally related to the Qualifying Diagnosis, no Offset will apply. If we have information regarding a traumatic brain injury but you do not check this box, we will have to apply the Offset and reduce any Supplemental Monetary Award by 75%. |



**1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM****VI. MEDICARE, MEDICAID AND OTHER LIEN INFORMATION**

Section VI addresses whether the Retired NFL Football Player: (1) has participated in a government or private medical plan; or (2) has any Liens that could be asserted against a potential Supplemental Monetary Award. If so, and there is a potential Lien to be asserted against the Supplemental Monetary Award, check YES then complete the appropriate section or sections. If you need to identify multiple programs, entities, or lienholders, copy the applicable page to provide the additional information and attach it to the completed Supplemental Claim Form. If the Retired NFL Football Player has no potential Lien that could be asserted against the Supplemental Monetary Award, check NO.

**VI.A. Medicare**

|     |                                                                                                              |                                                                                                                                                                                                                                                                      |
|-----|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 27. | <b>Has the Retired NFL Football Player been enrolled at any time in a Medicare Part A or Part B program?</b> | If the Retired NFL Football Player has been enrolled at any time in either a Medicare Part A or Part B plan, enter the following information about the Medicare plan: (a) HICN (Medicare Claim #); and (b) enrollment date using this format: MM/DD/YYYY.            |
| 28. | <b>Has the Retired NFL Football Player been enrolled at any time in a Medicare Part C program?</b>           | If the Retired NFL Football Player has been enrolled at any time in a Medicare Part C program, enter the following information about the Medicare plan: (a) name of the plan; (b) member number for the plan; and (c) enrollment date using this format: MM/DD/YYYY. |
| 29. | <b>Has the Retired NFL Football Player been enrolled at any time in a Medicare Part D program?</b>           | If the Retired NFL Football Player has been enrolled at any time in a Medicare Part D program, enter the following information about the Medicare plan: (a) name of the plan; (b) member number for the plan; and (c) enrollment date using this format: MM/DD/YYYY. |

**VI.B. Medicaid**

|     |                                                                                                                                                |                                                                                                                                                                                                           |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 30. | <b>If the Retired NFL Football Player is currently enrolled in a state Medicaid Program, provide the following information</b>                 | Enter the following information about the state Medicaid Program: (a) Medical ID number; (b) abbreviation for the state of issuance; and (c) enrollment date using this format: MM/DD/YYYY.               |
| 31. | <b>If the Retired NFL Football Player has been enrolled in any other state Medicaid Program at any time, provide the following information</b> | Enter the following information about any additional state Medicaid Program(s): (a) Medical ID number; (b) abbreviation for the state of issuance; and (c) enrollment date using this format: MM/DD/YYYY. |

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

|     |                                                                                 |                                                                                                                                                                                                                                                                                                     |
|-----|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 32. | <b>Department of Veterans Affairs health care or prescription drug benefits</b> | Check the box labeled "Department of Veterans Affairs health care or prescription drug benefits," if applicable, and enter the following information: (a) Claim Number; (b) Dates of Enrollment using this format: MM/DD/YYYY; (c) Branch; (d) Sponsor; (e) Sponsor SSN; and (f) Treating Facility. |
|-----|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM**

|                                           |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>33.</b>                                | <b>TRICARE health care or prescription drug benefits</b>                                                                                                                                                                                                                                                                                                                                                       | Check the box labeled "TRICARE health care or prescription drug benefits," if applicable, and enter the following information: (a) Claim Number; (b) Dates of Enrollment using this format: MM/DD/YYYY; (c) Branch; (d) Sponsor; (e) Sponsor SSN; and (f) Treating Facility.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>34.</b>                                | <b>Indian Health Service health care or prescription drug benefits</b>                                                                                                                                                                                                                                                                                                                                         | Check the box labeled "Indian Health Service health care or prescription drug benefits," if applicable, and enter the following information: (a) Claim Number; (b) Dates of Enrollment using this format: MM/DD/YYYY; (c) Branch; (d) Sponsor; (e) Sponsor SSN; (f) Tribe; and (g) Treating Facility.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>VI.D. Other Governmental Payor</b>     |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>35.</b>                                | <b>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</b> | Enter the following information about any Other Governmental Payors: (a) name of each entity; (b) policyholder name; (c) policy number; and (d) the medical condition for which the entity provided assistance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>VI.E. Private Healthcare Insurance</b> |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>36.</b>                                | <b>If the Retired NFL Football Player has received medical treatment for the Qualifying Diagnosis that was covered by a private insurance plan or other form of payment, provide the following information for every such plan or entity</b>                                                                                                                                                                   | <p>Enter the following information about the additional medical treatment you received: (a) name of each entity; (b) policyholder name; (c) policy number; and (d) the medical condition for which the entity provided medical treatment.</p> <p>Do not list disability or medical benefits available under the NFL Collective Bargaining Agreement, including the benefits available under the Bert Bell/Pete Rozelle NFL Player Retirement Plan; NFL Player Supplemental Disability Plan, including the Neuro-Cognitive Disability Benefit provided for under Article 65 of the Collective Bargaining Agreement; the 88 Plan; Gene Upshaw NFL Player Health Reimbursement Account Plan; Former Player Life Improvement Plan; NFL Player Insurance Plan; and/or the Long Term Care Insurance Plan.</p> |

## 1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM

### VI.F. Other Lien Information

|     |                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 37. | <b>Identify any known Lien of any nature whatsoever not identified previously in Section VI</b> | <p>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.</p> <p>Enter the name of the lienholder and the amount of the Lien. Enter whatever contact information you have for the lienholder, including mailing address, email address, and telephone number. Provide a brief description of the lien (e.g., child support garnishment). You must also provide a copy of the letter, form, or writing from the lienholder that informed you of the Lien.</p> |
|-----|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### VII. BANKRUPTCY INFORMATION

|     |                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 38. | <b>If at any time the Retired NFL Football Player has been a debtor in a bankruptcy proceeding, provide the following information</b> | <p>If at any time the Retired NFL Football Player was a debtor in a bankruptcy proceeding, check YES. Enter the District Name and State for the U.S. Bankruptcy Court overseeing the case. Enter the seven-digit case number and check the appropriate box to indicate the bankruptcy chapter. Enter the bankruptcy filing date (<i>i.e.</i>, the date the petition was filed to begin the case) using this format: MM/DD/YYYY. If the bankruptcy is closed, enter the closing date using the same MM/DD/YYYY format. If the case is still open, leave this space blank, even if you already received a discharge. If the Retired NFL Football Player has never been a debtor in a bankruptcy proceeding, check NO.</p> |
|-----|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### VIII. DUTY TO UPDATE

It is your responsibility to notify the Claims Administrator of any changes or updates to your information. 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 mailing address.

## 1. HOW TO FILL OUT THE SUPPLEMENTAL CLAIM FORM

### IX. SIGNATURE

A **Personal Signature** is required from either the Retired NFL Football Player or the Representative Claimant, as applicable, in Section IX of the Supplemental Claim Form. A Personal Signature is an actual original “wet ink” signature on a hard copy of this Supplemental Claim Form, or a PDF or other electronic image of an actual signature. Attorneys **cannot** sign this Supplemental Claim Form on behalf of their clients because it is prohibited by Section 30.2(a) of the Settlement Agreement.

|     |                     |                                                                              |
|-----|---------------------|------------------------------------------------------------------------------|
| 31. | <b>Signature</b>    | Sign your full name.                                                         |
| 32. | <b>Date</b>         | Enter the date that you signed the Claim Form using this format: MM/DD/YYYY. |
| 33. | <b>Printed Name</b> | Enter your first name, middle initial, last name and suffix (if applicable). |

## 2. HOW TO SUBMIT THE SUPPLEMENTAL CLAIM FORM

Submit the Supplemental Claim Form using one of these methods. **Do not return this instruction booklet with the Supplemental Claim Form.**

**By Mail:**

(must be postmarked on or before the deadline date)

NFL Concussion Settlement  
Claims Administrator  
P.O. Box 25369  
Richmond, VA 23260

**By Delivery:**

(must be placed with the carrier on or before the deadline date)

NFL Concussion Settlement  
c/o BrownGreer PLC  
250 Rocketts Way  
Richmond, VA 23231

## 3. HOW TO ASK QUESTIONS ABOUT THE SUPPLEMENTAL CLAIM FORM

If you have any questions about the Supplemental Claim Form or the Settlement Program, contact the Claims Administrator using one of these methods, or visit [www.nflconcussionsettlement.com](http://www.nflconcussionsettlement.com) to view a list of Frequently Asked Questions.

**U.S. Mail**

NFL Concussion Settlement  
Claims Administrator  
P.O. Box 25369  
Richmond, VA 23260

**Email**

[ClaimsAdministrator@NFLConcussionSettlement.com](mailto:ClaimsAdministrator@NFLConcussionSettlement.com)

**Toll-Free Telephone Number**

1-855-887-3485

**Law Firm Contacts**

If you are an attorney, call or email your law firm contact directly.

#### 4. USEFUL SETTLEMENT AGREEMENT DEFINITIONS

|    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | <b>Active List</b> means the list of all players physically present, eligible and under contract to play for a Member Club on a particular game day within any applicable roster or squad limits set forth in the applicable NFL or American Football League Constitution and Bylaws.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 2. | <b>Active Roster</b> means the list of all players physically present, eligible and under contract to play on a World League of American Football, NFL Europe League, or NFL Europa League team. For the avoidance of any doubt, a player on the Active Roster is not assigned to the Inactive List or Injured List.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 3. | <b>Derivative Claimants</b> mean spouses, parents, children who are dependents, or any other persons who properly under applicable state law assert the right to sue independently or derivatively by reason of their relationship with a Retired NFL Football Player or deceased Retired NFL Football Player.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 4. | <b>Eligible Season</b> means a season in which a Retired NFL Football Player or deceased Retired NFL Football Player was: (i) on a Member Club's Active List on the date of three or more regular season or postseason games; or (ii) on a Member Club's Active List on the date of one or more regular or postseason games, and then spent at least two regular or postseason games on a Member Club's injured reserve list or inactive list due to a concussion or head injury. A "half of an Eligible Season" means a season in which a Retired NFL Football Player or deceased Retired NFL Football Player was: (i) on a Member Club's practice, developmental, or taxi squad roster for at least eight regular or postseason games; or (ii) on a World League of American Football, NFL Europe League, or NFL Europa League team's active roster on the date of three or more regular season or postseason games or on the active roster on the date of one or more regular or postseason games, and then spent at least two regular or postseason games on the World League of American Football, NFL Europe League, or NFL Europa League injured reserve list or team inactive list due to a concussion or head injury. |
| 5. | <b>Governmental Payor</b> means 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, including, but not limited to, the Medicare Program, the Medicaid Program, TRICARE, the Department of Veterans Affairs, and the Indian Health Service.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 6. | <b>Lien</b> means any statutory lien of a Government Payor or Medicare Part C or Part D Program sponsor; or any mortgage, lien, pledge, charge, security interest, or legal encumbrance, of any nature whatsoever, held by any person or entity, where there is a legal obligation to withhold payment of a Monetary Award, Supplemental Monetary Award, Derivative Claimant Award, or some portion thereof, to a Settlement Class Member under applicable federal or state law.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 7. | <b>Member Club</b> means any past or present member club of the NFL or any past member club of the American Football League.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 8. | <b>Monetary Award</b> means the payment of money from the Monetary Award Fund to a Settlement Class Member, other than a Derivative Claimant, as set forth in ARTICLE VI of the Settlement Agreement. The term "Monetary Award" shall also include "Supplemental Monetary Award" with respect to the claims process set forth in the Settlement Agreement, including, without limitation, relating to submission and approval of claims, calculation and distribution of awards, and appeals.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 9. | <b>NFL Football</b> means the sport of professional football as played in the NFL, the American Football League, the World League of American Football, the NFL Europe League, and the NFL Europa League. NFL Football excludes football played by all other past, present or future professional football leagues, including, without limitation, the All-American Football Conference.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

#### 4. USEFUL SETTLEMENT AGREEMENT DEFINITIONS

|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10. | <b>NFL Medical Committees</b> mean the various past and present medical committees, subcommittees and panels that operated or operate at the request and/or direction of the NFL, whether independent or not, including, without limitation, the Injury and Safety Panel, Mild Traumatic Brain Injury Committee, Head Neck and Spine Medical Committee, General Medical Committee, Musculoskeletal Committee, Foot and Ankle Subcommittee, Cardiovascular Health Subcommittee, and Medical Grants Subcommittee, and all persons, whether employees, agents or independent of the NFL, who at any time were members of or participated on each such panel, committee, or subcommittee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 11. | <b>NFL Parties</b> mean the National Football League and NFL Properties LLC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 12. | <b>Offsets</b> mean downward adjustments to Monetary Awards, as set forth in Section 6.7(b) of the Settlement Agreement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 13. | <b>Personal Signature</b> means the actual signature by the person whose signature is required on the document, which may be submitted by an actual original “wet ink” signature on hard copy (either on the Claim Form or on an acknowledgement form verifying the contents of the Claim Form), or a PDF or other electronic image of such actual signature, but cannot be submitted by an electronic signature within the meaning of the Electronic Records and Signatures in Commerce Act, 15 U.S.C. §§7001, et seq., the Uniform Electronic Transactions Act, or their successor acts.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 14. | <b>Qualifying Diagnosis</b> means Level 1.5 Neurocognitive Impairment, Level 2 Neurocognitive Impairment, Alzheimer’s Disease, Parkinson’s Disease, ALS, and/or Death with CTE, as set forth in Exhibit 1 (Injury Definitions) of the Settlement Agreement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 15. | <b>Released Parties</b> , for purposes of the Released Claims, mean (i) the NFL Parties (including all persons, entities, subsidiaries, divisions, and business units composed thereby), together with (ii) each of the Member Clubs, (iii) each of the NFL Parties’ and Member Clubs’ respective past, present, and future agents, directors, officers, employees, independent contractors, general or limited partners, members, joint venturers, shareholders, attorneys, trustees, insurers (solely in their capacities as liability insurers of those persons or entities referred to in subparagraphs (i) and (ii) above and/or arising out of their relationship as liability insurers to such persons or entities), predecessors, successors, indemnitees, and assigns, and their past, present, and future spouses, heirs, beneficiaries, estates, executors, administrators, and personal representatives, including, without limitation, all past and present physicians who have been employed or retained by any Member Club and members of all past and present NFL Medical Committees; and (iv) any natural, legal, or juridical person or entity acting on behalf of or having liability in respect of the NFL Parties or the Member Clubs, in their respective capacities as such; and, as to (i) and (ii) above, each of their respective Affiliates, including their Affiliates’ officers, directors, shareholders, employees, and agents. For the avoidance of any doubt, Riddell is not a Released Party. |
| 16. | <b>Representative Claimants</b> mean authorized representatives, ordered by a court or other official of competent jurisdiction under applicable state law, of deceased or legally incapacitated or incompetent Retired NFL Football Players.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 17. | <b>Retired NFL Football Players</b> mean all NFL Football players who, prior to the date of the Preliminary Approval and Class Certification Order, retired, formally or informally, from playing professional football with the NFL or any Member Club, including American Football League, World League of American Football, NFL Europe League and NFL Europa League players, or were formerly on any roster, including preseason, regular season, or postseason, of any such Member Club or league and who no longer are under contract to a Member Club and are not seeking active employment as players with any Member Club, whether signed to a roster or signed to any practice squad, developmental squad, or taxi squad of a Member Club.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |



#### 4. USEFUL SETTLEMENT AGREEMENT DEFINITIONS

|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 18. | <b>Riddell</b> means Riddell, Inc.; All American Sports Corporation; Riddell Sports Group, Inc.; Easton-Bell Sports, Inc.; Easton-Bell Sports, LLC; EB Sports Corp.; and RBG Holdings Corp., and each of their respective past, present, and future Affiliates, directors, officers, employees, general or limited partners, members, joint venturers, shareholders, agents, trustees, insurers (solely in their capacities as such), reinsurers (solely in their capacities as such), predecessors, successors, indemnitees, and assigns.                                                                         |
| 19. | <b>Settlement Class Member</b> means each Retired NFL Football Player, Representative Claimant and/or Derivative Claimant in the Settlement Class; provided, however, that the term Settlement Class Member as used herein with respect to any right or obligation after the Final Approval Date does not include any Opt Outs.                                                                                                                                                                                                                                                                                    |
| 20. | <b>State of Domicile</b> means the state where the Retired NFL Football Player primarily lived and intended to make his home at the time of the Qualifying Diagnosis.                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 21. | <b>Stroke</b> means stroke, as defined by the World Health Organization's International Classification of Diseases, 9th Edition (ICD-9) or the World Health Organization's International Classification of Diseases, 10th Edition (ICD-10), which occurs prior to or after the time the Retired NFL Football Player played NFL Football and is unrelated to NFL Football play. A medically diagnosed Stroke does not include a transient cerebral ischaemic attack and related syndromes, as defined by ICD-10.                                                                                                    |
| 22. | <b>Traumatic Brain Injury</b> means severe traumatic brain injury unrelated to NFL Football play, that occurs during or after the time the Retired NFL Football Player played NFL Football, consistent with the definitions in the World Health Organization's International Classification of Diseases, 9th Edition (ICD-9), Codes 854.04, 854.05, 854.14 and 854.15, and the World Health Organization's International Classification of Diseases, 10th Edition (ICD-10), Codes S06.9x5 and S06.9x6 whereunder you lost consciousness for more than 24 hours and did not return to pre-existing conscious level. |





# 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                                                                    |                    | ____/____/____<br>(Month/Day/Year) |                      |        |
| Player Date of Death (if applicable)                                                    |                    | ____/____/____<br>(Month/Day/Year) |                      |        |
| Player Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen) |                    | ____ - ____ - ____<br>or<br>____   |                      |        |
| Player Mailing Address                                                                  | Address 1          |                                    |                      |        |
|                                                                                         | Address 2          |                                    |                      |        |
|                                                                                         | City               |                                    |                      |        |
|                                                                                         | State/Province     |                                    | If Non-US:           |        |
|                                                                                         | Postal Code        |                                    | Country              |        |
| Player Telephone                                                                        | ____ - ____ - ____ |                                    | Player Email Address |        |

## SUPPLEMENTAL CLAIM FORM FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS

### 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.

|                                                                                                        |                                                                                                                                                                          |      |                                     |        |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------|--------|
| <b>Representative Name</b>                                                                             | First                                                                                                                                                                    | M.I. | Last                                | Suffix |
| <b>Representative Date of Birth</b>                                                                    | <div style="display: flex; justify-content: space-around;"> <span>____/____/____</span> </div> <div style="text-align: center; font-size: small;">(Month/Day/Year)</div> |      |                                     |        |
| <b>Representative Social Security Number, Taxpayer ID or Foreign ID Number (if not a U.S. Citizen)</b> | <div style="display: flex; justify-content: space-around;"> <span>_____</span> <span>or</span> <span>_____</span> </div>                                                 |      |                                     |        |
| <b>Representative Mailing Address</b>                                                                  | Address 1                                                                                                                                                                |      |                                     |        |
|                                                                                                        | Address 2                                                                                                                                                                |      |                                     |        |
|                                                                                                        | City                                                                                                                                                                     |      |                                     |        |
|                                                                                                        | State/Province                                                                                                                                                           |      | If Non-US:                          |        |
|                                                                                                        | Postal Code                                                                                                                                                              |      | Country                             |        |
| <b>Representative Telephone</b>                                                                        | <div style="display: flex; justify-content: space-around;"> <span>_____ - _____ - _____</span> </div>                                                                    |      | <b>Representative Email Address</b> |        |

### 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.

|                               |                                                                                                       |      |                             |        |
|-------------------------------|-------------------------------------------------------------------------------------------------------|------|-----------------------------|--------|
| <b>Lawyer Name</b>            | First                                                                                                 | M.I. | Last                        | Suffix |
| <b>Law Firm Name</b>          |                                                                                                       |      |                             |        |
| <b>Lawyer Mailing Address</b> | Address 1                                                                                             |      |                             |        |
|                               | Address 2                                                                                             |      |                             |        |
|                               | City                                                                                                  |      |                             |        |
|                               | State/Province                                                                                        |      | If Non-US:                  |        |
|                               | Postal Code                                                                                           |      | Country                     |        |
| <b>Lawyer Telephone</b>       | <div style="display: flex; justify-content: space-around;"> <span>_____ - _____ - _____</span> </div> |      | <b>Lawyer Email Address</b> |        |

# SUPPLEMENTAL CLAIM FORM FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS

## 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                                                                                            |
|------------------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------------------------------------------------------------------------------|------|-----------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Level 2 Neurocognitive Impairment</b>                              |       | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(Month/Day/Year)</div> |      | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(State)</div> |
| 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                                                                                                                            |
| <input type="checkbox"/> <b>Alzheimer's Disease</b>                                            |       | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(Month/Day/Year)</div> |      | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(State)</div> |
| Diagnosing medical professional:                                                               |       |                                                                                                                                            |      |                                                                                                                                   |
| Name                                                                                           | First | M.I.                                                                                                                                       | Last | Suffix                                                                                                                            |
| <input type="checkbox"/> <b>Parkinson's Disease</b>                                            |       | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(Month/Day/Year)</div> |      | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(State)</div> |
| Diagnosing medical professional:                                                               |       |                                                                                                                                            |      |                                                                                                                                   |
| Name                                                                                           | First | M.I.                                                                                                                                       | Last | Suffix                                                                                                                            |
| <input type="checkbox"/> <b>ALS (Amyotrophic Lateral Sclerosis, or "Lou Gehrig's Disease")</b> |       | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(Month/Day/Year)</div> |      | <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center; font-size: small;">(State)</div> |
| Diagnosing medical professional:                                                               |       |                                                                                                                                            |      |                                                                                                                                   |
| Name                                                                                           | First | M.I.                                                                                                                                       | Last | Suffix                                                                                                                            |

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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%.

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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.
- ☐ **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%.

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**VI. MEDICARE, MEDICAID AND OTHER LIEN INFORMATION**

As set forth in Article XI of the Settlement Agreement, the Lien Resolution Administrator is administering the process for the identification, verification, and satisfaction of Liens that may be withheld or asserted against your Monetary Award. If you or the Lien Resolution Administrator identifies a potential Lien asserted against your Monetary Award and the Lien Resolution Administrator confirms the validity and final amount of such Lien(s), the Lien Resolution Administrator is required to deduct those amounts from your Monetary Award along with any other deductions required by state or federal law. If the final amount needed to resolve a Medical Lien has not yet been determined after your Award has been funded, the Lien Resolution Administrator will apply a holdback amount that it believes is reasonably necessary to satisfy pending Medical Liens and that will maximize the payments to you at the earliest possible stage. If the final Lien amount exceeds the amount of the holdback, the Monetary Award Fund and NFL Parties will not be responsible for satisfying any portion of the Lien, you are responsible for any unpaid portion of the lien, and the Lien Resolution Administrator will require you to return funds necessary to fully satisfy the lien.

This Section of the Claim Form: (1) defines the scope of the Lien Resolution Administrator's services; (2) collects health insurance coverage information; and (3) establishes the Lien Resolution Administrator's authority to resolve potential repayment obligations with Medicare (Part A and Part B), Medicaid, the Department of Veterans Affairs ("VA") / Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA"), TRICARE, Indian Health Service, and any self-reported private healthcare insurance/plan. By signing this Claim Form, you authorize the Lien Resolution Administrator to exchange your/the Retired NFL Football Player's personal and health information and act on your behalf with each of these agencies/groups.

**Medicare:** The Lien Resolution Administrator will affirmatively perform verification of past or current Medicare (Part A and Part B) entitlement using information provided in Section I (first and last name, date of birth, Social Security Number) and gender. The Lien Resolution Administrator will resolve any Medicare recovery claim for a Retired NFL Football Player determined to be a Medicare beneficiary.

**State Medicaid, VA/CHAMPVA, TRICARE, and Indian Health Service:** The Lien Resolution Administrator will resolve potential repayment obligations with those agencies and/or insurers that you identify in this Claim Form. If you do not report coverage on the Claim Form, or you provide incomplete coverage information, the Lien Resolution Administrator may not take action with respect to these agencies/insurers. Should any Lien obligation arise with any agency/insurer not reported on the Claim Form or that the Lien Resolution Administrator did not identify, it is solely your responsibility to resolve that Lien directly with the agency/insurer.

**Private Healthcare Insurers:** The Lien Resolution Administrator will resolve potential repayment obligations with those private healthcare insurers and/or plans that you identify in this Claim Form, if you indicate that you would like the Lien Resolution Administrator to verify and resolve any Lien(s) asserted by those insurers and/or plans. Do not contact or report any Monetary Award to Medicare, a governmental agency, or private healthcare insurer that you report on this Claim Form. Such activity could cause duplication and delay in the Lien Resolution Administrator's process.

Did the Retired NFL Football Player have and use any healthcare coverage for medical care, goods, or services related to treatment of the claimed Qualifying Diagnosis/es or injury(ies)?

- ☐ **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.

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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:                    /            / \_\_\_\_\_

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)

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**B. Medicaid**

Has the Retired NFL Football Player ever had Medicaid benefits?

☐ **YES** If you answered Yes, provide additional information about the Medicaid plan(s). Then go to Section VII. C.

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

☐ **UNSURE** Check Unsure if you do not know if the Retired NFL Football Player has ever had Medicaid benefits. For any Settlement Class Member who answers Unsure, the Lien Resolution Administrator will affirmatively perform verification of current state Medicaid entitlement using the information provided in Section I (state of mailing address, first and last name, date of birth, Social Security Number). The Lien Resolution Administrator will resolve any state Medicaid recovery claim for those Retired Players determined to be Medicaid beneficiaries. If you answered Unsure, go to Section VII. C.

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: \_\_\_\_/\_\_\_\_/\_\_\_\_ **TO** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

Branch: \_\_\_\_\_

Sponsor: \_\_\_\_\_

Sponsor SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

Treating Facility: \_\_\_\_\_

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

Claim Number: \_\_\_\_\_

Enrollment Dates: \_\_\_\_\_ **TO** \_\_\_\_\_  
(Month/Day/Year) (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: \_\_\_\_\_

\_\_\_\_\_

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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: \_\_\_\_\_

For the private healthcare plan/entity identified above, select one of these options:

☐ I **would** like the Lien Resolution Administrator to verify and resolve any possible Lien asserted by the plan or entity identified in Section VII.E of this Claim Form.

☐ I **would not** like the Lien Resolution Administrator to verify and resolve any possible Lien asserted by the plan or entity identified in Section VII.E of this Claim Form. I understand that some or all my Monetary Award or Derivative Claimant Award may be withheld until the Claims Administrator receives documentary proof, such as a court order or release or notice of satisfaction by the party asserting the Lien, that the Lien has been satisfied or discharged, in accordance with Section 11.3(h) of the Settlement Agreement.

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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)

**SUPPLEMENTAL CLAIM FORM  
FOR RETIRED NFL FOOTBALL PLAYERS AND REPRESENTATIVE CLAIMANTS**

**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.**

|                     |       |             |                                    |
|---------------------|-------|-------------|------------------------------------|
| <b>Signature</b>    |       | <b>Date</b> | ____/____/____<br>(Month/Day/Year) |
| <b>Printed Name</b> | First | M.I         | Last                               |



# CONCUSSION SETTLEMENT

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

## INSTRUCTIONS FOR COMPLETING THE DIAGNOSING PHYSICIAN CERTIFICATION FORM

If you received a diagnosis from a doctor who is a Qualified MAF Physician, have him or her fill out the MAF Diagnosing Physician Certification Form.

Your doctor must follow the instructions and fill out all of the fields to the best of his or her knowledge.

If your doctor has already completed a Diagnosing Physician Certification Form and submitted it directly to us, you do not need to complete another form.

**If you have any questions or need any help completing your Supplemental Claim Package:**

**Call 1-855-887-3485**

**Email [ClaimsAdministrator@NFLConcussionSettlement.com](mailto:ClaimsAdministrator@NFLConcussionSettlement.com)**

**Visit [www.NFLConcussionSettlement.com](http://www.NFLConcussionSettlement.com)**



# CONCUSSION SETTLEMENT

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

## MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM (for a Qualifying Diagnosis made by a Qualified MAF Physician)

This MAF Diagnosing Physician Certification Form is to be used only by a Qualified MAF Physician in the NFL Concussion Settlement to report that a Retired NFL Football Player has a Qualifying Diagnosis under the terms of the Settlement Agreement.

**Do not sign this form if you did not personally examine the Retired NFL Football Player.** If you are a Qualified BAP Provider certifying a diagnosis you made in the Baseline Assessment Program, do not use this form; use the BAP Diagnosing Physician Certification Form instead.

Complete this entire form, sign it and provide it to the Claims Administrator (and to the Retired NFL Football Player, if requested) along with all medical records and other information you created or received regarding this Retired NFL Football Player, as required in the Rules Governing Qualified MAF Physicians. The Claims Administrator will review everything submitted.

If you have any questions, contact the Claims Administrator by phone (toll free) at 1-855-887-3485, by email at [ClaimsAdministrator@NFLConcussionSettlement.com](mailto:ClaimsAdministrator@NFLConcussionSettlement.com), or visit the Settlement Website at <https://www.nflconcussionsettlement.com>.

**MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM**  
**(for Qualifying Diagnoses made by Qualified MAF Physicians)**

## I. INFORMATION ON THE RETIRED NFL FOOTBALL PLAYER

|                               |  |                                                                                                                                                                                                                                        |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
|-------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------|------|--|--|--|--------|--|
| Settlement Program ID         |  |                                                                                                                                                                                                                                        |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
| Name                          |  | First                                                                                                                                                                                                                                  |  |  |                                                                                                                                                                                                                                            | M.I. |         | Last |  |  |  | Suffix |  |
| Address                       |  | Address 1                                                                                                                                                                                                                              |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
|                               |  | Address 2                                                                                                                                                                                                                              |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
|                               |  | City                                                                                                                                                                                                                                   |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
|                               |  | State/Province                                                                                                                                                                                                                         |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
|                               |  | Postal Code                                                                                                                                                                                                                            |  |  |                                                                                                                                                                                                                                            |      | Country |      |  |  |  |        |  |
| Telephone                     |  | <div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>-</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>-</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> |  |  |                                                                                                                                                                                                                                            |      |         |      |  |  |  |        |  |
| Date of Birth                 |  |                                                                                                                                                                                                                                        |  |  | <div> <div></div> <div></div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>(Month/Day/Year)</div> |      |         |      |  |  |  |        |  |
| Date of Death (if applicable) |  |                                                                                                                                                                                                                                        |  |  | <div> <div></div> <div></div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div> <div>(Month/Day/Year)</div> |      |         |      |  |  |  |        |  |

## II. INFORMATION ON THE QUALIFIED MAF PHYSICIAN

|                                    |       |                |      |
|------------------------------------|-------|----------------|------|
| National Provider Identifier (NPI) |       |                |      |
| Physician Name                     | First | Middle Initial | Last |
| Office/Practice Name               |       |                |      |

**MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM**  
**(for Qualifying Diagnoses made by Qualified MAF Physicians)**

### III. EXAMINING NEUROPSYCHOLOGIST (IF ANY)

Did a neuropsychologist assist you in making the Qualifying Diagnosis?

☐ YES      ☐ NO

If you answered Yes, identify that neuropsychologist. The neuropsychologist must be either a Qualified BAP Provider or someone approved by the Claims Administrator for use in this Program, and his or her practice must be located within 50 miles of your office (unless an exception has been granted).

|                               |       |                |      |
|-------------------------------|-------|----------------|------|
| <b>Neuropsychologist Name</b> | First | Middle Initial | Last |
| <b>Office/Practice Name</b>   |       |                |      |

#### IV. QUALIFYING DIAGNOSIS

Identify your diagnosis and the date of the diagnosis. Select one diagnosis only.

| Qualifying Diagnosis                                         | Date of Diagnosis                                                          |
|--------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Level 1.5 Neurocognitive Impairment | _____ _____ ___ / _____ _____ ___ / _____ _____ _____ <br>(Month/Day/Year) |
| <input type="checkbox"/> Level 2 Neurocognitive Impairment   | _____ _____ ___ / _____ _____ ___ / _____ _____ _____ <br>(Month/Day/Year) |
| <input type="checkbox"/> Alzheimer's Disease                 | _____ _____ ___ / _____ _____ ___ / _____ _____ _____ <br>(Month/Day/Year) |
| <input type="checkbox"/> Parkinson's Disease                 | _____ _____ ___ / _____ _____ ___ / _____ _____ _____ <br>(Month/Day/Year) |
| <input type="checkbox"/> ALS (amyotrophic lateral sclerosis) | _____ _____ ___ / _____ _____ ___ / _____ _____ _____ <br>(Month/Day/Year) |



**MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM**  
**(for Qualifying Diagnoses made by Qualified MAF Physicians)**

**FOR DIAGNOSES OF LEVEL 1.5 OR LEVEL 2 NEUROCOGNITIVE IMPAIRMENT:**

If you and/or the examining neuropsychologist making a diagnosis of Level 1.5 or Level 2 Neurocognitive Impairment used diagnostic criteria that differ from those set forth in the Settlement Agreement for Level 1.5 or Level 2 conditions diagnosed in the Baseline Assessment Program ("BAP"), you must explain any deviation from the BAP diagnostic criteria. Obtain information from the examining neuropsychologist as necessary to provide a complete explanation. Deviation from the BAP diagnostic criteria occurs and an explanation must be provided when:

- (a) BAP Test Battery Results:** The Retired NFL Football Player was administered the complete BAP Test Battery used in the Baseline Assessment Program and the resulting test scores do not meet the thresholds necessary to support the Qualifying Diagnosis under the BAP criteria in Settlement Agreement Ex. 2.
- (b) Incomplete BAP Test Battery:** The neuropsychological test battery administered to the Retired NFL Football Player was not the complete BAP Test Battery.
- (c) Additional Testing:** The neuropsychological tests administered to the Retired NFL Football Player included tests that are not part of the BAP Test Battery.
- (d) Performance Validity Testing:** The Retired NFL Football Player was assigned scores or results indicating that the player failed two or more of the embedded and/or stand-alone performance validity measures in the neuropsychological test battery and/or where the application of the clinical criteria for assessing performance validity under Slick *et al.* otherwise indicates that the test data may not be a valid reflection of his optimal level of neurocognitive functioning.
- (e) Disagreement About the Retired NFL Football Player's Diagnosis:** The Retired NFL Football Player was administered the complete BAP Test Battery, but your conclusion differs from that of the examining neuropsychologist. Confer with the neuropsychologist where you disagree on the proper diagnosis. If there is still disagreement, you must explain, based on your personal examination of the Retired NFL Football Player, medical records and sound medical judgment, the basis of your diagnosis.

**MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM**  
**(for Qualifying Diagnoses made by Qualified MAF Physicians)**

(1) Did the neuropsychological testing and/or your medical evaluation of this Retired NFL Football Player differ from the BAP diagnostic criteria in any of these ways?

☐ **YES**      ☐ **NO**

**If you answered Yes**, describe how, based on your medical judgment and the supporting medical evidence, the diagnosis is “generally consistent” with the BAP diagnostic criteria. Your explanation cannot be a mere conclusion. Instead, explain the specific reason(s) why you believe the Retired NFL Football Player has the Level 1.5 or Level 2 diagnosis even though his evaluation deviated from the BAP diagnostic criteria (attach additional pages if needed).

**MAF DIAGNOSING PHYSICIAN CERTIFICATION FORM**  
**(for Qualifying Diagnoses made by Qualified MAF Physicians)**

(2) If you provided a diagnosis of Level 2 Neurocognitive Impairment, did you determine that certain tests in the BAP testing protocol were medically unnecessary because of the severity of the Retired NFL Football Player's dementia (see your Qualified MAF Physician Manual and the Clinician's Interpretation Guide)?

☐ **YES**      ☐ **NO**

**If you answered Yes**, list the tests or criteria that were deemed unnecessary and the medical evidence supporting your determination (attach additional pages if needed):

**V. CERTIFICATION**

By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that I personally examined the Retired NFL Football Player named in Section I and that all information provided in this form is true and correct to the best of my knowledge, information and belief.

**Signature of  
Qualified MAF  
Physician**

**Date of  
Signature**

|\_|\_|\_|\_|/|\_|\_|\_|\_|/|\_|\_|\_|\_|  
(Month/Day/Year)

**Printed Name**

First

M.I.

Last

Suffix