MISSOURI FAMILY SUPPORT DIVISION
PO BOX 2710
JEFFERSON CITY, MO 65102-2710

Missouri Department of SOCIAL SERVICES
Your Potential. Our Support.

STATE OF MISSOURI
19th JUDICIAL CIRCUIT

LINDA GERKEN, *et al.*,	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 06AC-CC00123-03
	)	Division IV
STEVE CORSI, *et al.*,	)	
Defendants.	)	

CLAIM FORM FOR ELIGIBLE MEMBERS

I,_____[name of Eligible Member] either personally or through my authorized representative, hereby submit a claim for reimbursement for the underpayment of blind pension benefit payments made to me, or made on my behalf, by the Department of Social Services between February 1, 2001, and June 30, 2010, and I hereby certify that I was eligible for and received at least one blind pension payment during that time period. I further state, subject to penalty of perjury that the following information is true to the best of my own personal knowledge, information and belief:

****

To be completed by the Eligible Member [or for the Eligible Member by the Eligible member's authorized representative]:

1. I received blind pension payments for one or more months beginning February 1, 2001, and ending June 30, 2010.

2. My current mailing address is:

   _____
   _____
   _____

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3. My current residence address (if different from mailing address) is:

_____
_____
_____

4. I would like all correspondence, information and payments mailed to me at:

Either_____Residence address
Or _____Mailing Address;
Or Other address:

_____
_____
_____

5. My current e-mail address is: _____

6. My social security number is: _____

7. My Date of Birth is:_____

8. My Department Client Number (DCN) is: _____

9. My phone number is: _____

The undersigned states that the foregoing information is made under affirmation, and its representations are true and correct to the best of my knowledge and belief, subject to penalties of making a false declaration.

Date_____ Eligible Member

****

To be completed by the Eligible Member's authorized representative [if appropriate]:

1. I hereby certify that I am the authorized representative of _____ [name of member]. I certify subject to penalty of perjury that the information that I have provided in this claim form is true and accurate to the best of my own personal knowledge, information and belief.

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2. I am either:

_____The Eligible Member's Attorney [Attach Entry of Appearance]; or

_____The Attorney-in-Fact of the Eligible Member by valid affidavit [Attach Affidavit]; or

_____ The Eligible Member's court appointed guardian [Attach a certified copy of the Letters of Appointment and/or Copy of Court order of appointment];

_____ The personal representative of the estate of a deceased Eligible Member, or the attorney for the estate. [Attach a copy of the Letters of Appointment and/or copy of court order of appointment];

_____The surviving spouse or heirs where there is no probate estate. [Attach Exhibit G or H].

3. To the best of my knowledge, the Eligible Member received blind pension payments for one or more months beginning February 1, 2001, and ending June 30, 2010

4. The Eligible Member's current address and telephone number are:

Address: _____

_____

_____

Telephone Number: _____

E-mail: _____

5. My current mailing address is:

_____

_____

_____

6. My current residence address (if different from mailing address) is:

_____

_____

_____

7. I would like all correspondence, information and payments mailed to me on behalf of the Eligible member at:

Either_____Residence address

Or _____Mailing Address;

Or Other address:

_____

_____

_____

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8. My current e-mail address is: _____

9. The Eligible Member's social security number is: _____

10. The Eligible Member's Date of Birth is:_____

11. The Eligible Member's Department Client Number (DCN) is: _____

12. The Authorized Representative's Phone Number is: _____

The undersigned states that the foregoing information is made under affirmation, and its representations are true and correct to the best of my knowledge and belief, subject to penalties of making a false declaration (must complete notary form below).

Date_____ Authorized Representative

****

State of _____

County/City of _____

On this_____day of_____in the year 20 before me,_____, a Notary Public in and for said state, personally appeared_____, known to me to be the person who executed the within claim form, and acknowledged to me that he/she executed the same for the purposes therein stated.

Seal Notary Public