

STATE OF MISSOURI
19th JUDICIAL CIRCUIT

LINDA GERKEN, <i>et al.</i> ,)	
Plaintiffs,)	
)	
v.)	Case No. 06AC-CC00123-03
)	Division IV
GARY SHERMAN, <i>et al.</i> ,)	
Defendants.)	

NOTICE DECLINING PAYMENT

I _____, hereby notify the Department of Social Services that (circle one) I decline to accept any reimbursement that may be due to me in this matter/ request a lesser amount. I understand that by signing this document I am forever waiving any claim to compensation on this matter.

I choose a lesser amount. Amount requested _\$ _____

My social security number is: _____

My Date of Birth is: _____

My Department Client Number (DCN) is: _____

My phone number is: _____

By signing below, I hereby waive any and all rights or claims to any such reimbursement and release all parties hereto and their counsel from any claim or liability whatsoever arising out of for related to this matter.

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. (No notary is required).

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.

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]; or

____ The personal representative of the estate of a deceased Eligible Member, or the
attorney for the estate.

[Attach certified copy of the Letters of Appointment and/or copy of court order of
appointment].

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:

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. Authorized Representative phone number: _____

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. (No notary is required).

Date _____

Authorized Representative