THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM LEXINGTON COUNTY
Court of Common Pleas

The Honorable Eugene C. Griffith, Jr.

Case No. 2011-CP-32-04981
Appellate Case No. 2014-000671

Mike Russell, ... Respondent,

v.

Randolph Gill and Pennsylvania Life Insurance Company..... Defendants,

Of Whom Pennsylvania Life Insurance Company is ..... Appellant.

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STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF LEXINGTON

MIKE RUSSELL,

Plaintiff,

vs. CASE NO. 2011-CP-32-04981

RANDOLPH GILL AND PENNSYLVANIA LIFE INSURANCE COMPANY,

Defendants.

DEPOSITION OF:	MIKE RUSSELL
DATE:	October 24, 2012
TIME:	1:11 p.m.
LOCATION:	Law Offices of Nelson, Mullins, Riley & Scarborough, LLP 1320 Main Street, 17th Floor Columbia, South Carolina
TAKEN BY:	Counsel for the Defendants
REPORTED BY:	ANGELA D. ZUVER, Court Reporter

A. WILLIAM ROBERTS, JR., & ASSOCIATES
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STIPULATIONS

It is stipulated by and between Counsel that this deposition is being taken in accordance with the South Carolina Rules of Civil Procedure, Rule 30; that all objections as to Notice of this deposition are hereby waived; that all objections except as to form are reserved until the time of trial; and that the deponent waives reading and signing of this deposition.

* * * * * * * * * *

MIKE RUSSELL

being first duly sworn, testified as follows:

EXAMINATION

BY MS. HORNE:

Q. Mr. Russell, my name is Kristen Horne, and we're here today to take your deposition in the matter of Russell versus Penn Life. For the record, the name of Pennsylvania Life Insurance Company has been changed to Union Bankers Insurance Company, but today for all of our purposes we'll keep calling them Penn Life. I just wanted to make sure we've noted that change.

You've just been sworn in. Are you able to give testimony today in this matter?

A. Yes.

Q. Are you under the influence of any other medicine or situation that would prevent you from being able to give accurate and truthful answers today?

A. No.

Q. Have you ever had your deposition taken before?

A. No.

Q. Okay. Well, the rules for a deposition are pretty simple. You've met our court reporter. She's taking everything that way say down and writing it into a transcript for us so it's important that we give verbal responses and communication today instead of head nodding or uh-huhs and huh-uhs that are difficult to transcribe. So try to keep that in mind while we're talking today.

If you need any breaks for any reason, just let us know and we'll take a break.

If you don't understand a question that I ask, will you please ask me to rephrase it or restate it?

A. Yes.

Q. If you answer a question that I've asked then we'll all assume that you understood it;

is that fair?

A. Yes.

Q. Okay. Will you please state your full name for the record?

A. Michael Clyde Russell.

Q. What's your birth date?

A. [redacted].

Q. What's your Social?

A. [redacted].

Q. [illegible]

A. Correct.

Q. What's your current address?

A. [illegible]

Q. Where were you born?

A. Alton, Illinois.

Q. Where is that?

A. Just below Springfield, as far as I know. I've never been.

Q. Not since that day?

A. About six months. And then we moved to Tennessee.

Q. To Tennessee?

A. Yes.

Q. So you moved to Tennessee when you were

a baby. How long did you live in Tennessee?

A. Until I was 14.

Q. Where were you in Tennessee?

A. Elk Valley. Do you want me to name every town? We lived in about 15 different places.

Q. Oh my goodness. Why did you move around so much?

A. Jobs.

Q. Your parents' jobs?

A. Yeah.

Q. What kind of work were they doing that they had to move around so much?

A. My dad -- coal mining.

Q. And then when you were 14 you moved from Tennessee to where?

A. Pontiac.

Q. In the northeast part of Columbia?

A. Correct.

Q. And you moved there when you were 14?

A. Yes.

Q. How long were you there?

A. Four months, and then we moved to Gaston.

Q. Were you 15 then?

A. No. It would have been in the summer,

so, yeah, I should have been. And we lived there for about a year or so and then we moved -- actually, the other place we moved to was still in Gaston, so it really didn't help matters much. Yeah, we lived in Gaston.

Q. You stayed in Gaston. And then where did you live next?

A. Where I built my house at, actually.

Q. So when did you leave Gaston?

A. Let me see. My dad died in '90 -- excuse me -- '86. '88.

Q. You built your house in '88?

A. No. No. I was still a kid in '88. My dad died in '88. We left that area about a year later, maybe a little less than a year, and we moved -- my mom had bought the property where I now have my house built.

Q. Okay. On Dogwood Road?

A. Right. So it would have been mid '89, early '90 when she purchased that land and we moved there.

Q. You said that you built the house that you live in now?

A. Yes, ma'am. When we moved there it was a mobile home and after my mom -- my mom lived

there for four or five years and I lived with her. She met a new husband and moved out on Lake Murray. So I just started renting the property from her. Then when she passed away I bought out my brothers and sisters and lived in that mobile home for a couple of years. And then eight years ago me and my wife bought the property beside of us, lived there, tore down the mobile home, and I built my house.

Q. In what year did you build your house?

A. It was eight years ago. So what's that, '04?

Q. Yes.

A. So it would have been 2004.

Q. Okay. What's the address of the property that the mobile home was on?

A. The address I gave you.

Q. It's

A. Correct.

Q. Okay. I saw some things that showed 1463, but I couldn't tell --

A. That was where I moved to when I built my house.

Q. So you were at 1469, then 1463, then back at

A. Right.

Q. Okay. Thanks. So you've lived on the property where you are now for how many years?

A. Counting -- including when I was a kid?

Q. Uh-huh.

A. 21, 22 years now.

Q. What community activities are you involved in? Are you a member of any --

A. I don't really do community activities.

Q. Any clubs?

A. No.

Q. Organizations? Church?

A. No.

Q. No volunteer activities or anything like that?

A. No.

Q. Have you ever sued anybody or been sued by anybody before?

A. No.

Q. Not --

A. I've had to put liens on property. I don't know if you consider that suing.

Q. Like mechanic's liens?

A. Right. Actually, I say I had to put liens on property. The threat of it was enough.

I've had to do that three times, but all three times they paid out before the lien actually took effect. So ...

MR. RILEY: You're lucky.

THE WITNESS: Not really. I still have a builder to this day that owes me $32,000 that I did not get the lien in place. I was unaware of the 60-day notice. He kept dragging it out until the 60 days passed. Then I was unable to do anything about it. So I wouldn't consider myself too terribly lucky.

BY MS. HORNE:

Q. Do you have any criminal history? I'm sorry to ask, but ...

A. No, ma'am. I was arrested one time for disorderly conduct.

Q. When was that?

A. It's -- I'm going to say between 2000 and 2003. I really don't remember the year. It just wasn't a big deal to me.

Q. What was going on?

A. A police officer had made my wife get out of a car that she was driving -- I was in the passenger seat -- and I did not much appreciate the way he asked so I got out to make sure my wife was

safe.

Q. What's the name of that song? There's a guy who wrote a song about that almost exact situation.

A. Oh, really?

Q. It has an expletive in it. It's very funny. Not that the situation is funny, but the song. His response to that was quite funny.

A. I understand.

Q. Have you ever been convicted of any crimes other than traffic violations?

A. No.

Q. Tell me about the traffic tickets that you've gotten.

A. Several speeding tickets. That's really about it.

Q. I saw somewhere -- was there a failure to show proof of insurance in maybe 2005?

A. Yes. I was rear-ended by a young lady on Mineral Springs Road and I was unable to find my insurance card.

Q. Have you been charged with any crimes related to alcohol or drugs?

A. No.

Q. Are you married?

A. Yes.
Q. What's your wife's name?
A. Susanne Russell.
Q. How does she spell her name?
A. S-U-S-A-N-N-E.
Q. How long have you been married?
A. Eleven years. Wait a minute.
Q. I won't tell her that you can't remember.
A. Let's go with 11. It might actually be 14, but I'm having a hard time remembering the date now.
Q. It's a good thing she's not here.
A. I'll be sure to look that up when I get home.
Q. What's your anniversary day? Do you remember that?
A. Yes, ma'am. It is August the 9th.
Q. Well, I hope you got her something nice this year.
A. Actually, we decided not to do anything. We're going to go to Tennessee for a couple days later in the year. So ...
Q. That'll be fun.
A. Yes.

Q. Have you ever been married to anybody else?

A. No.

Q. You got married 11 years ago. Was that 2001 maybe?

A. No. That's not right.

Q. That's okay.

A. Goodness. I can't believe --

Q. That's okay. Do you have any children?

A. No.

Q. Where did you go to high school?

A. Airport.

Q. For all four years?

A. No, ma'am. Just one.

Q. One year of high school?

A. Yes, ma'am.

Q. Did you graduate high school?

A. No. That was the year my dad died or the year after my dad died and it just became impossible for me to live with my mom.

Q. So what did you do next?

A. Went to work.

Q. Went to work?

A. Yeah.

Q. Did you go to any -- do you have a GED

or anything like that?

A. No.

Q. Where did you go to work?

A. Ralph McCulley was the gentleman that I went to work for.

Q. McCollough?

A. McCulley.

Q. How does that name get spelled?

A. She actually should know. She's from Ohio. M-C-C-U-L-L-E-Y I believe is how he spelled it.

Q. And what job were you doing with Mr. McCulley?

A. Installation of vinyl siding, roofing, framing. Pretty much any type of construction that needed to be done at the time.

Q. When did you start working for him?

A. '91.

Q. Right after your first year of high school?

A. Right. Right after I quit high school.

Q. Was that in the summertime or ...

A. No. It would have to have been early spring because I -- well, it might have been '92 that I started with him because I'm thinking it was

springtime that I started working for him. So it must have been '92 when I started working with him.

Q. You said it was an Ohio name. Was this job in Ohio?

A. No, ma'am. That was here. He was from Ohio.

Q. Where was that job? Where was he located?

A. His office and everything was located in Irmo, but our jobs were all over the city.

Q. Did you have any training or background to prepare you to be able to do that job of installing siding and doing construction work?

A. I was raised on a cattle farm. So, yeah, I'd done quite a bit of construction work during those years building barns, building lofts and so forth. So, yeah, I was kind of a self-taught construction worker, more or less.

Q. So you started working for Mr. McCulley in 1991 or 1992. How long did you work with him?

A. Eight years.

Q. So until 1999 or 2000?

A. Correct.

Q. What did you do next?

A. Started my own business.

Q. What's the name of that business?
A. Then it was Russell Home Improvement.
Q. And that was in 2000?
A. 2000 or 2001, correct.
Q. What did Russell Home Improvement do?
A. Same thing, installation of vinyl siding, roofing, framing.
Q. Did you have any licenses or certifications when you did that work?
A. No. It's not required.
Q. So you said then it was called Russell Home Improvement. Did you change the name of that business?
A. Yes, ma'am. Roughly six years after I started Russell Home Improvement, which would have been around 2005 or 2006, it changed to MCR Construction, LLC.
Q. And the change -- why did you change the name?
A. To become incorporated. Russell Home Improvement was already incorporated in Spartanburg. You can't have the same in the same state so I had to come up with a different name.
Q. What kind of corporation is it?
A. LLC. Limited liability.

Q. So you've worked for yourself for quite some time, and you worked for Mr. McCulley. Have you had any other jobs?

A. While I was in high school I worked at McDonald's for about five months which ironically is where I met Mr. McCulley. His wife was a manager there.

Q. Things work out, don't they?

A. Yes, they do.

Q. Were you ever in the military?

A. No.

Q. What are your sources of income?

A. Right now?

Q. Uh-huh.

A. My wife.

Q. What does she do?

A. CPA.

Q. Is she with a firm or --

A. Yes.

Q. What's the --

A. Barb & Company.

Q. I'm sorry?

A. Barb & Company.

Q. Where are they located?

A. They just moved about two months ago.

It's off of Forest Drive, but I do not know the exact address off the top of my head.

Q. That's okay. How long has she been with them?

A. Eight years.

Q. Do you get any disability from Social Security?

A. No.

Q. Have you applied?

A. No. Actually, let me take that back. I think my wife checked into it during the eight months that Penn Life denied paying me anything. I think my wife checked into it then, but they denied the claim and we have not messed with it since.

Q. You haven't gone back to reapply?

A. I figured if they denied me, they denied me. There wasn't nothing I could do about it.

Q. So we talked about your wife's job. Do you have any other income?

A. No.

Q. Do you own your home?

A. The bank owns it. I mean we make mortgage --

Q. You have a mortgage on it?

A. Yes, ma'am.
Q. How much do you owe on it?
A. I'm going to say around 75, maybe 85. In that area.
Q. What's your mortgage payment?
A. 375. I actually paid for the house when I built it, didn't have a mortgage, but then we bought property to sell later and so I put it against the house. So that's the reason why the mortgage is so low.
Q. I see. So you took out a mortgage on your property to buy investment property?
A. Right.
Q. Do you still have investment property?
A. One of them.
Q. Where is it?
A. Lake Murray.
Q. Where?
A. It's 33 Lake Murray Subdivision. I think that's right.
Q. Where is that?
A. It's in Saluda.
Q. I'm trying think. I go out 378, I cross over that little --
A. Go through the traffic circle, turn

right on Highway 90. You go a little ways down through there. You turn left. I think it's Wild Wood. Quite honestly, I would have to get directions because I've not been to it in probably five years.

Q. Does it have a house on it or a trailer?

A. No, ma'am. It's just land.

Q. So you're not -- are you renting it to anybody?

A. No, ma'am. It's just trees. Squirrels won't pay rent.

Q. Somebody might want to fish on it. When did you buy that property?

A. It was after I built my house. So I'm going to say 2006, but it could be minus a year or plus a year on that. I really don't remember the date off the top of my head.

Q. Have you purchased other investment properties?

A. No, ma'am.

Q. That's the only piece that you've ever bought?

A. Well, outside of the property directly beside of my house where I lived while I built my

house. But I have since sold it.

Q. That's the 1463?

A. Correct.

Q. Okay. Do you own any cars?

A. Cars?

Q. Uh-huh.

A. No. I own plenty of trucks.

Q. What kinds of vehicles do you own?

A. I own a 2008 F-350, I own a 2004 F-550, a 2000 F-350, and I've sold the rest of them.

Q. When did you sell them?

A. Actually, it was only the other 550 that I sold, and that would have been right around the time of my accident. Actually, the year before my accident is when I put Sammy Cullen in business. So, yeah, the year before my accident. That would have been '07.

Q. I remember what I was going to ask you. Do you personally own this 33 Lake Murray Subdivision piece of property or is it in your wife's name?

A. It's in both of our names.

Q. Jointly?

A. Yes.

Q. We talked about your trucks. Do you

own any other vehicles?

A. Does a boat count?

Q. It's got a motor on it, doesn't it?

A. It does.

Q. What kind of boat is it?

A. It is a 2008 Bass Tracker 18-foot.

Q. What color is it?

A. Black and silver.

Q. Do you have any savings accounts?

A. Yes, ma'am.

Q. What banks?

A. First Citizens.

Q. Checking accounts?

A. Yes, ma'am.

Q. Which banks?

A. First Citizens also, business and personal.

Q. Do you have any retirement accounts, you and your wife?

A. I would assume that my wife does. I couldn't say anything else about that. I have no idea. But, no, I do not.

Q. You do not?

A. I do not.

Q. But you think she does?

A. I'm pretty sure she does.
Q. Is she the money person in your family?
A. Yes, ma'am.
Q. Sounds like it, with a CPA.
A. She would chop off my fingers if I tried to do it.
Q. Well, let's keep your fingers, please. Do you receive any Social Security checks?
A. No.
Q. What's the total amount of your monthly income?
A. Do you -- from Penn Life or --
Q. For your household.
A. I have no idea. I've never asked my wife what she makes. That sounds kind of odd now that I say that out loud.
Q. If she's taking care of it all then it works out fine.
A. Yeah.
Q. Do you know how much is in your savings accounts?
A. No, ma'am.
Q. Do you know about the checking accounts?
A. (Shaking head.)

Q. You just leave it all to her?
A. (Nodding head.)
Q. It's nice to have somebody in charge, isn't it? I think we've talked about everything. Can you think of any other sources of income or other investments that you've got?
A. No, ma'am. That property on Lake Murray is all the investment property that we have.
Q. So no other investment accounts or brokerage accounts?
A. Like I said, she very well might have some, but you would have to ask her. That's not something that we talk about. I have always tried to make it a point that the money I made was for the family and the money she made was for her to do whatever she wanted to or in case something ever happened to me at least then she would have it. So that's kind of the reason why we set up the way -- or the reason why I don't know anything, because I just never really bothered to find out.
Q. Were your medical bills covered by health insurance?
A. Yes.
Q. Do you still have health insurance?
A. Yes.

Q. Are you guys covering your expenses every month?

A. Yes.

(DFT. EXH. 1, Chart of payments, was marked for identification.)

BY MS. HORNE:

Q. I'm going hand you a document that's been labeled as Defendant's Exhibit Number 1. Excuse my reach.

MS. HORNE: This is a chart of payments and information that we filed with our motion for summary judgment, Nick. This is what we gave you all a while ago.

MR. RILEY: Yeah.

BY MS. HORNE:

Q. Can you look at that chart that's at the front of this packet and tell me -- did you receive all these payments from Penn Life?

A. I believe so, yes.

Q. Why did you sue Penn Life?

MR. RILEY: Objection to the form of the question. You can answer.

THE WITNESS: They skipped eight months without making a payment. They literally -- and every time I would call all I was told was the

policy was under review. That's all anyone would say and they would hang the phone up. And after dealing with that for about three to four months straight I just decided that a lawyer was my only other option.

BY MS. HORNE:

Q. When was the eight-month period that you didn't receive payments from Penn Life?

A. I would have to ask my wife the exact days on when it started and when they start -- when they started back. I do not recall off the top of my head.

THE WITNESS: That would have started right when I came to see you because they had mailed one check I'm going to say a month after I came to see -- whenever after I came to see you all. So it would have been the months leading up to that. That's been going on so long that I done forgot. That's been what, three years ago now?

MR. RILEY: Yeah.

BY MS. HORNE:

Q. So this chart only reflects the -- payments through March of 2010, because that was the time that we were filing these motions. Did you receive a benefit check dated November 22, '08

in the amount of 8,125?

A. Yes, ma'am. I believe so.

Q. Do you see this column that's listed Benefit Check Date in the middle of this chart?

A. Yes.

Q. Are there any checks that are listed on this chart that you could identify by that benefit check date that you did not receive?

A. I do not understand the question.

Q. Are there any checks that are listed on this chart that you did not receive?

A. I do not believe so, no.

Q. So do you know which payments you did not receive?

A. Well, eventually they had caught up with all of them, but as I said, they had skipped between six to eight months in a row. That's what forced me to go speak with an attorney to begin this process.

Q. But you're not sure which months those were?

A. No, ma'am, not -- as I told Nick a second ago, it would have started a month -- because I waited about a month before I got to see -- I don't even recall your boss's name off the top

of my head, but it would have been the months preceding that.

Q. Mr. Moore?

A. Correct.

Q. So you're not sure which payments were late?

MR. RILEY: Objection to the form of the question. You can answer.

THE WITNESS: You can count on one hand how many they've actually gotten on time, actually. But, no, I do not, not off the top of my head.

BY MS. HORNE:

Q. Did the payments that you received later than you'd like cause problems?

A. Of course.

Q. Exactly what problems?

A. It would have made my bills late.

Q. Exactly which bills were late?

A. It would have been a combination of all of them.

Q. Specifically which ones?

A. Electric, satellite.

Q. Which electric bills were late?

A. I do not know the months off the top of my head.

Q. Which satellite bills were late?

A. I do not know the months off the top of my head. Again, I do not pay the bills at my house. My wife does.

Q. Were there any other adverse consequences?

A. Just causing marital problems for me and my wife because money was so tight.

Q. Were there any other financial problems?

A. No.

Q. Let's talk about how you got the insurance policy that we're talking about today.

A. Okay.

Q. How long have you had this disability insurance policy?

A. Fifteen years now.

Q. You took out a disability policy sometime in 1999; is that correct?

A. Thereabouts, yes.

(DFT. EXH. 2, Policy Schedule, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Defendant's Exhibit Number 2. The first page is

stamped at the bottom with Russell 0145; is that correct? Or did the sticker cover it maybe?

A. I'm sorry. What was the question again?

Q. Underneath your thumb right there do you see that the first page is stamped as --

A. Yes.

Q. -- Russell 0145?

Okay. This document shows the insurance policies that you have. I just wanted to read the first line that says monthly total disability benefit $2,000. What's the effective date that's next to that?

A. 11/1999.

Q. Okay. So that's when you first -- around about the time that you first got the policy?

A. Correct.

Q. Who did you work with to get the policy?

A. John something. I honestly couldn't tell you his name.

Q. Do you remember what agency he was with or how you met him?

A. He just showed up on the job site I was

working at one day is how I met him.

Q. And did you talk to him that day and submit an application that day or --

A. No. It was a process of -- my wife is very anal when it comes to giving someone our checking account information. So she had to call the Better Business Bureau to verify that that was a legitimate company and everything like that. So that process took two or three weeks I'm sure.

Q. And then did you meet with John back at your job site or someplace else?

A. It would have been somewhere else.

Q. Do you remember --

A. My house, if I'm not mistaken.

Q. That sounds likely. What did you do during that meeting?

A. Just discussed the policy.

Q. What did you tell him?

A. That I would like to have the policy.

Q. What policy?

A. The Pennsylvania Life policy.

Q. A disability policy?

A. Correct.

Q. Did you tell him anything else?

A. I honestly couldn't say yes or no to

that. That was 15 years ago.

Q. Do you remember asking for anything specific?

A. Not really, no.

Q. And so you completed the application. Did he fill it out or did you fill it out?

A. I'm sure I would have filled out the application.

Q. And then you signed it?

A. Yes.

Q. Okay. And then the next section down on that piece of paper, it says monthly total disability benefit $500. What's the date that's next to that?

A. 7/19/02.

Q. So when did you get this additional disability benefit?

A. 7/19/02.

Q. How did you get it?

A. John had -- I had spoken with John a couple times throughout that year, and just knowing what my bills were I know that $2,000 a month would not be enough to cover my bills. And I asked John if it was possible to have that raised, and he said, no, that is the legal limit for the state of

South Carolina. Well, later that year the state had changed that law and he was able to offer another $500 onto that. So then I agreed to add that $500 to my policy.

Q. Did you meet with John about that policy?

A. Yes. At least I think it was John.

Q. How did you meet Randy Gill?

A. I don't think I met Randy until I started dealing with the issues of the policy itself.

Q. What does that mean?

A. When I started going through the -- no. To be perfectly honest with you, I do not remember when I met Randy, but for some reason I'm thinking it was around the time I started filing the claims after my accident.

Q. Do you think that you met with him to complete the application for the additional benefit coverage?

A. I remember that being John, but I guess it could have been Randy. Honestly, I don't know.

Q. You don't remember?

A. Yeah.

Q. If you can look at the next few pages

of the document that's been marked as Exhibit 2. The first page says application for insurance?

A. Correct.

Q. Is that your handwriting?

A. Looks like it, yeah.

Q. You think that's your handwriting?

A. (Nodding head.)

Q. Is that your handwriting on the next page?

A. I don't really see any writing. I see numbers.

Q. The numbers, do you think that looks like your handwriting or --

A. Sure.

Q. Did you complete this application or do you think whoever you were working with, either Randy Gill or John, who's last name you're not sure about, completed it?

A. Honestly, again, I would assume that I did it, but ...

Q. You don't remember for sure?

A. No.

Q. Okay. Were you trying to change from your old disability policy or were you just looking to expand your coverage?

A. Just expand my coverage.
Q. So you were happy with the policy?
A. Well, yeah. Up to that point I hadn't had to use it.
Q. Do you remember where you completed the application for the 2002 --
A. From the 2,000 until the 2,500?
Q. Uh-huh.
A. Again, I would assume that that took place at my house, but you know, I really can't say exactly where I was at?
Q. Okay. Do you remember how long it took to complete the application?
A. No.
Q. Do you remember talking with the person you were working with about any other matters?
A. Actually, I do recall having a conversation with them. I believe it was to have -- to add an additional cancer policy that he had mentioned to me. I was going to add it, but they had declined it. They declined that policy.
Q. Did you apply for it or just seek information about it?
A. No. I applied for it. They had rejected it. I don't even recall what the policy

was for now. I remember it being about cancer, but I don't remember much about it after that.

Q. Okay. Did you get the additional coverage that you wanted?

A. Yes.

Q. Was there anything that Randy Gill didn't do correctly?

A. Not that I can think of, no.

Q. Do you have a copy of your insurance policy?

A. I do.

Q. Have you had one since you were issued the policy?

A. I have. My attorney has it as of now.

Q. Did you talk to Mr. Gill or anybody at Penn Life about your insurance situation more -- after the time that you submitted this application to have extended -- expanded -- excuse me -- coverage or any other time before the wreck?

A. No.

Q. Let's talk now about your health situation. Did you have any health problems in the few years before the motorcycle wreck?

A. Yes.

Q. What kinds of health problems?

A. Early 2000 I had viral meningitis. I was out of work for about five months with that. No. About four months with that one.

Q. Where did you get treatment for that?

A. Lexington. Let's see. I had a tree fall on me. I want to say that was 2005. I was out of work for about six months on that one because that took a lot of time for my muscles in my neck to heal up.

Q. Where did the tree hit you?

A. On the top of my head. It knocked me out cold.

Q. Was anybody with you?

A. Yeah. Luckily there was four people. There was three other people. I was the fourth. There were three people there when it happened.

Q. Where does that happen?

A. In Sandy Run.

Q. At a job?

A. No, ma'am. That was deer hunting property. Me and those three gentlemen had just gotten the lease for that property and we were cleaning it up. We were just doing simple cleanup and --

Q. That's not the way you expect a workday

to go.

A. Yeah. Especially when it's 7:30 in the morning and a tree lands on the top of your head. That makes for a bad day. But anyway, like I said, I was out of work for about six months on that one.

I broke my left hand in -- that was after the tree hit me, so I would say 2006.

I cracked a rib in my back. Actually, I think that was 2006 as well. I missed several months on that.

I had a hernia operation. That happened while I was in the process of building my house. So that would have been in 2004 when I had the hernia operation. I think that's all of them.

Q. Did any of the health issues that you just talked about affect your day-to-day living?

A. Yes, ma'am.

Q. In what ways?

A. Well, I mean after several of the accidents I was unable to work. After that tree hit me I was unable to move.

Q. You said that you've had a hernia operation. Have you had any other surgeries?

A. Not counting the accident that we're here for?

Q. Right.

A. No, ma'am. He was the only person that ever operated on me.

Q. How was your eyesight before the accident?

A. Basically 20/20.

Q. When did you start wearing glasses? I see that you're wearing glasses today.

A. Yes, ma'am. Just recently. I have had severe headaches for about eight months and my doctor recommended that I see if the glasses would help relieve those headaches.

Q. Is it working?

A. No, ma'am. But my vision is only slightly off in my right eye. I actually had to have a chip of brick drilled out of my right eye in 1999 -- this is before the policy took effect -- and that's kind of why that eyesight is what it is in that eye. And, yeah, it is a painful as it sounds.

Q. I can't even imagine. Do you have any stomach problems?

A. No.

Q. Intestinal problems?

A. No.

Q. Acid reflux problems?
A. No.
Q. Never?
A. (Shaking head.)
Q. Have you ever had any dizziness prior to the motorcycle wreck?
A. No.
Q. Were you taking any medications regularly?
A. No.
Q. No antacids?
A. (Shaking head.)
Q. Aspirins?
A. I would rarely even take a Tylenol for a headache until this accident.
Q. Were you on any pain medications for any of the injuries or surgeries that we just talked about?
A. Yes, ma'am. When the tree hit me I was on pain medication for about three and a half months to four months.
Q. What were you on?
A. Honestly, I could not tell you the names of them off the top of my head. It's varied. Every hospital uses different pain regimens. So I

would have to get my medical records to know exactly what I was on.

Q. Do you use any antihistamines like Zyrtec or benadryl or anything like that?

A. No.

Q. Did you take any muscle relaxers in June of 2008?

A. No. At least not until after the accident.

Q. Prior to the accident?

A. No.

Q. Sleeping pills?

A. No.

Q. Are you working right now?

A. No.

Q. What was your job with your business at the time of the motorcycle wreck?

A. Installation of vinyl siding.

Q. Specifically vinyl siding installation?

A. Correct. The company I was working for here in Columbia had -- in the business they're referred to as a track builder. So I was responsible for anywhere between 200 to 350 a houses a year for them.

Q. What was that company?

THE WITNESS: Nick, do I really have to get them involved?

MR. RILEY: Well, the tract -- I don't really know how you would be getting them involved.

Let's go off the record for a second.

(Off-the-record conference.)

BY MS. HORNE:

Q. Will you say the answer that you just gave?

A. Yes. The Mungo Company.

Q. So tell me -- you said that you were working for Mungo and you were doing 200 to 350 houses a year? Is that what I understand?

A. Yes, ma'am.

Q. So tell me how that worked. You were a subcontractor for them?

A. Correct.

Q. What did you do?

A. Just installed the vinyl siding on their houses as they built them. Like I said, it varied. I had up to as many as 13 contractors working with me at one time.

Q. What does that mean?

A. I had 13 individuals working with me at one time that I would subcontract to to enlist

their help on a particular house.

Q. Were you supervising the work for those 13 folks?

A. No, ma'am. I worked on the house with them. There's not enough money in residential work to stand around and look at it. If you're not nailing the siding up you're not making any money.

Q. So you had about 13 people. How many houses would you have going on at one time?

A. One at a time. We started and finished a house typically in a day to a day and a half, depending on the size of the home.

Q. And it was you and how many other of these individuals working with you?

A. Every house varied. Depending on how many showed up, you know, that particular day, but generally I would have between 10 to 13 of them there on a given day.

Q. So it's you and a whole team of people?

A. Right.

Q. I misunderstood that a second ago. I'm sorry.

A. I actually had the majority of them with me for the better part of ten years. So they were well trained and knew exactly what I expected

of them. So we were able to get the houses done and go on to the next one.

Q. How did you get your jobs from Mungo?

A. I started off there with just me and two other -- actually, just me and one other guy, like I said, 18, 19 years ago and just built up from there. You know, they went from having responsibility of doing one house a week to where I was handling four or five houses a week for them.

Q. How did you get the houses?

A. Just dealing with the superintendents up there.

Q. The superintendents would hire you for each project or did you have a contract?

A. No, ma'am. There was no contract. It was based on a house-by-house basis basically.

Q. So the superintendent would call you and say --

A. Correct. This house is ready. Lot so-and-so is ready. You know, here's the color. And then I would have to go by, verify that the house was ready, make sure the siding colors were installed or were available at my supplier to get picked up, get everything ordered and pick the material up that afternoon to go to that house the

next day.

Generally I would do it house by house evening by evening for the simple fact homeowners were prone to doing what they would call a change order where after they signed a contract they have up to 60 days to change the color if they don't like it. They'd say, well, I don't like that color vinyl, I want this color. And we'd had a couple of instances where I was given a color, but the homeowner had changed it.

So we stopped doing it -- I used to be able to go in and say, all right, give me houses for the next upcoming week, but that happened where we had installed the wrong color on a house where it had gotten changed but the order did not make it to me before we installed it. So we stitched back to doing it day by day. That way I knew I had the proper color.

Q. Did you coordinate with the folks who were working with you every day also?

A. Yes, ma'am. I was on a job site every day.

Q. But you're saying that you'd get the supplies and things in the evening when you've confirmed that all the details were correct?

A. Correct.

Q. Did you confirm your staff and stuff then as well?

A. Pretty much so. I mean the majority of the time that was known the morning before. I mean I'll know going into a week -- because I know each subdivision as well as I do I'll know which houses should be ready for the next upcoming week. So I can tell them guys basically a week in advance, I'll need you every day next week or four days next week. So for the most part it was five days a week.

Q. How many hours a week do you think you worked?

A. It varied. Obviously it depended on the weather. We don't work in the rain. We melt. But generally 36 to 40 hours a week.

Q. And how many houses a week was that?

A. Again, it varied depending on the weather and what was available, but, you know, it would go from -- basically a house a day is what we would do. That's the reason why I kept that many guys around, because it was -- if I didn't do it somebody else would. So ...

Q. Had it been pretty steady work for a

while?

A. Oh, yes, ma'am. I worked -- I hadn't missed -- working for them, I hadn't missed ten days in ten years from lack of work.

Q. Were things slowing down in the beginning of 2008 with the economy or was business still --

A. Business was still going when I got hurt. I had, I think, 11 houses waiting on me.

Q. Will you break down the sorts of tasks that you were doing in a day to complete a project and to get ready for a project and tell me how much time you were spending doing those things?

A. Well, again, it varies depending on the size of the house that you're doing. You know, obviously a thousand square foot home doesn't take near as much effort or time as a 3000 square foot house does. So basically my morning would start off -- during the summer months we would leave -- which is typically our busy time. You know, we would leave at 4:30, quarter to 5:00 in the morning, arrive on the job site at 5:30, quarter to 6:00, and by 6 o'clock we were swinging hammers. And that's basically what we done until a house was done. And, again, with that many people, it makes

the work go really quick.

So we would spend six to eight hours doing those houses, you know, doing that house, and that would -- from starting that early that freed up my afternoons. So that allowed me to get the next house ready. And that would just vary depending on where I worked at that day. You know, if I was working in Irmo and my next house was in the northeast then I would spend, you know, 45 minutes or so driving out there, looking at the house.

The superintendents would not always be honest with you when they'd call and say the house was ready. You know, it might be missing three windows out back, but they just rode by and said, yeah, it looks ready. But they don't get out and walk the jobs every day so they don't know if the windows are missing or not. Before I bring that many people to a job site I have to know for sure that the job is indeed ready.

So then I would spend my afternoon riding to the next house, getting it ready, confirming the colors, getting everything ordered from my supplier, and then we would pick it up that afternoon or pick it up the following morning, but

generally it was picked up in the afternoon before because we like to get started so early. If we waited for the suppliers to drop it off it would be 9:30, 10 o'clock before they delivered it.

The F-350 and the 2000 that I told you about, that truck has a 14-foot flatbed and we used it to haul all of our material for every job.

Q. Did you have anybody who rode with you?

A. Oh, yeah. Certainly. Actually, that job typically fell to someone else. I have my truck that I drove and then I had other people that drove my work trucks. And it varied. You know, generally that truck was driven by my brother.

Q. I'm sorry. Repeat that. I didn't hear you.

A. That particular truck, the one we picked the material up with, was driven by my brother.

Q. Did you work with your brother?

A. He worked for me, yeah.

Q. What's his name?

A. Sam Cullen.

Q. How do you spell his last name?

A. C-U-L-L-E-N.

Q. What did he do for you?

A. Installation of vinyl siding.
Q. And he drove the truck?
A. Yes, ma'am. Like I said, one of them.
Q. And he picked up the material often?
A. Yes. The majority of the time he was the one that was responsible for that.
Q. What else did he do for you?
A. Outside of being a younger brother, that was about it really. I mean, you know, he you just -- he was a good, hard worker, showed up every day like he was supposed to. So ...
Q. How much money were you making at the time of the wreck?
A. Me or him?
Q. You.
A. Me. My income varies I mean from -- I mean I would say as an average -- you know, low 50s would be an average a year for what would be -- what I would make. But it varied just like, you know, any construction worker's will. It depends on how many houses you got done that week and what each one of them paid.
Q. How much money was your business making?
A. Per year?

Q. Uh-huh.

A. Net or gross?

Q. Both.

A. Net I would say 1.2, 1.4.

Q. Million?

A. Yes, ma'am. And take out the material bills, I ran in the 4 to $700,000 a year range, to labor being in the $300,000 a year. My business was making probably about 50, 55,000 a year. Because the rest of it went to everybody else. As it does.

Q. What were your injuries from the accident? I don't want to talk about the accident itself, but what were your injuries from the accident?

A. Shattered pelvis, shattered pelvic on the left side, compound fracture of the lower left leg.

Q. Like near your ankle or --

A. Yes, ma'am. About four inches up from my ankle. Both the bones of my lower left leg were sticking out of the skin.

Q. What were your physical limitations right after the wreck?

A. Right after the wreck I couldn't move.

It hurt to breathe.

Q. What would you spend your time doing?

A. Staring at the walls.

Q. Anything else?

A. No, ma'am. I wasn't able to do anything else.

Q. How has that changed?

A. I'm able to get around on my leg now so I can at least spend some time outside, but it really hasn't changed. Physically I'm still not able to do much of anything.

Q. What do you do during the day?

A. Watch television. Stare at the walls.

Q. Can you drive?

A. Yes, ma'am. As long as I'm not taking my pain medication.

Q. How often do you take that?

A. Twice a day.

Q. What are you taking?

A. Hydrocodone. The 10-325s. And I also have a Fentanyl patch that I wear continuously.

Q. What does that do?

A. It's supposed to magnify the effects of the pain medicine just to help it help better, I guess. I'm not real sure that it works, though.

Q. Do you fish or hunt?

A. Both, actually.

Q. Where do you fish?

A. You know, I say I fish, but it's -- with the shape that my hip's in it's almost impossible for me to get out on my boat just from hitting the waves. Just the impacts are so hard it just makes it impossible for me to really get out on my boat so I can't really say that I fish anymore.

Deer hunt. My wife and her sister were left some property in Fairfield from her dad when he passed away. So I hunt out there.

Q. My husband hunts in Fairfield. I can't think of the name of the club.

A. I'm not a member of a club. It's just 56 acres that Larry Cartee owned. That was her dad's name, my wife's dad's name. He owned it before he passed away. So I hunt there. It's got a mobile home on it that we stay in while we're out there.

Q. How often do you get to go?

A. Probably a weekend a month.

Q. Do you stay for the whole weekend?

A. Yes, ma'am.

Q. Have you gotten anything good?
A. No.
Q. Have you seen anything this year?
A. I have picture of some beautiful ones.
Q. From one of those cameras that get --
A. Stills?
Q. Yeah.
A. A ten and a 12 were up there, but I haven't been able to see either one of them yet.
Q. Do you hunt in a tree stand?
A. No, ma'am. I have a ground blind. I don't do much climbing anymore.
Q. What about the other property that you were at when you got hit in the head with that tree limb, do you ever hunt out there?
A. No. We lost that lease. At the end of that year, actually, we lost that lease. A doctor from Florida offered the landowners more money than what we were willing to pay.
Q. What else do you do for fun? Do you have any other hobbies?
A. No.
Q. No collections? No --
A. No.
Q. Nothing?

A. Stare at the walls.

Q. How long can you stand up?

A. I mean I've never timed it so I can't say for 35 minutes or 45 minutes.

Q. Just generally.

A. It really varies. You know, as most people that are in pain can vouch for, it's a good day/bad day scenario. You know, some days you have good days, some days you have bad days. Typically, you know, 20 to 30 minutes is about as long as I care to be up on it. After that it really does go to hurting quite severely.

Q. How about sitting?

A. About the same.

Q. So what do you -- how do you spend your day managing that?

A. Back and forth from sitting to standing.

Q. Can you walk?

A. Yes.

Q. You can get outside?

A. Yes.

Q. I see that you have a cane with you. Do you walk with a cane?

A. The majority of the time, yes.

Q. If you're not using your cane what are you doing?

A. I'm somewhere close by a wall. Like throughout my house I don't have to use the cane because I can prop my hand up against the walls if I go to lose my balance. Because I have issues -- sometimes I'll get a real sharp pain that runs through my leg that will cause that leg to buckle and I'll fall over. So that's -- as long as I've got something close by to catch myself then I don't have to worry about it.

Q. Do you go to the grocery store or Wal-Mart?

A. No.

Q. Do you run any of the errands?

A. I mean -- well, I say that I do not. Occasionally I will go to the grocery store if it's to pick up one or two items that we might need, but as far as the Wal-Mart, no. I don't do Wal-Mart.

Q. Target? ---

A. No.

Q. Do you go to the movies?

A. No.

Q. Restaurants?

A. Not in about eight months.

Q. Why not?

A. My wife was diagnosed with fibromyalgia and when she gets off work all she really wants to do is rest and relax. So we pretty much are homebodies now.

Q. Do you travel at all?

A. Just to the deer hunt property.

Q. You said you were going to Tennessee. Are you going on vacation?

A. Yes, ma'am. I generally always go to Tennessee to visit my family for Thanksgiving. That's a trip me and my wife have made for -- well, since my mom died, actually. So that would have been since '04.

Q. What family do you still have in Tennessee?

A. I have 103 first cousins.

Q. 103 first cousins?

A. Uh-huh. My mom had nine sisters and two brothers. And my family is the smallest and there's five of us.

Q. That sounds like a party.

A. Yeah.

Q. What are the age ranges of the cousins?

A. Right now they range from -- let's see.

Jimmy is in his mid-30s. So he's the youngest. So from the mid-30s upwards into late 50s right now.

Q. Where do you have a Thanksgiving dinner for this many people?

A. My aunt's house.

Q. Really?

A. Uh-huh. And she does all the cooking too.

Q. How many people are there?

A. I don't bother trying to count because they kind of come and go.

Q. I see. Tell me about any other activities or things that you do or that you're able to do.

A. It's like I said. Watch television. When I get to hurting from sitting on the couch or a chair for so long then I'll get up and kind of move about the house. If it's nice out I always try to get out and spend at least 30 to 45 minutes out in the sun just -- I always seem to feel better when I'm out in the sunlight.

Q. Tell me about the physical problems that you have now.

A. Do you mean as far as walking?

Q. Just generally.

A. Well, mainly the walking is the physical aspect of it for me. It's, you know, the pain that's created from having the muscles and bones and ligaments damaged in that leg. Basically my left leg looks like a meat puzzle.

Q. That's the biggest problem that you've got, is walking?

A. Yes, ma'am.

Q. What about headaches?

A. I had a sharp pain come through the back of my head about nine months ago and it's pretty much stayed. I don't -- I've been -- I've had MRIs, taken CAT scans, and they can't seem to find anything wrong.

Q. Nine months ago. January?

A. Thereabouts, yeah.

Q. Have you ever had headaches like that before?

A. No. But my doctor said that it could have been -- viral meningitis can reappear in the form of severe headaches years later. So they assume that that's what it is right now, but they do not know for sure.

Q. Tell me about your hip.

A. What do you want to know?

Q. Well, how is -- we can talk more about your surgeries, I guess, later. But you've had hip replacement surgery; is that correct?

A. Yes, ma'am. Actually, I've had two surgeries on my hip. I had a doctor at Richland -- Dr. Iaquinto done the original surgery and -- well, let's just say he's not one of my favorite people. And then in 2009 -- in October of 2009 I had finally gotten in with Dr. Suarez at the Lexington Orthopaedics and he had went in and replaced the hip. Dr. Iaquinto had just basically put a patch over it.

Q. Did that surgery in 2009 improve your hip situation?

A. Definitely. Before that I wasn't even able to walk. I was still walking on crutches a year later because that doctor had done such a bad job rebuilding it.

Q. Have you had any depression?

A. No, not really.

Q. Anxiety?

A. No.

Q. What other problems have you experienced since the wreck?

A. I have a lot of pain in my right

shoulder that I think is a torn rotator cuff, but I haven't really had it looked at. And I still have issues with my left knee.

Q. Did you have any of that shoulder pain before the accident?

A. Not that I had recalled. But I do construction so I mean there's always something sore.

Q. Have you sought any professional counseling? I mean with a psychiatrist. Have you met with a psychiatrist?

A. No. That's what I have a wife for.

Q. What would you describe your disability as being?

A. I don't understand the question.

Q. Well, I mean if you were describing why you were disabled what would you tell someone?

A. That I have a fake left hip, a metal rod that holds my lower left leg together and a knee that has no cartilage in it. So ...

Q. What's your prognosis?

A. That I'll pretty much be in pain the rest of my life.

Q. Do you think you'll ever get better?

A. There's really no way for it to get

better. I mean as I age everything in there is just going to get that much harder to keep together. So it's actually going to get worse as I age.

Q. Do you think you'll ever be able to work?

A. Not construction, no. There's just no way I can carry that kind of weight day in and day out. I can barely carry my weight.

Q. What doctors were you seeing before the wreck?

A. Before the wreck?

Q. Uh-huh.

A. I wasn't seeing any doctors.

Q. Did you have a family --

A. Outside of the ones that I went to from all of the other accidents that I had had. And those were different doctors. I went from my family doctor to physicians at the Lexington Medical Center.

Q. Since the wreck what doctors have you been treated by?

A. Iaquinto done the original trauma surgery. I forget the doctor's name in Irmo that I saw for a couple of years for pain management. But

I dropped him. Dr. Suarez, who rebuilt or replaced the surgery.

Q. That's what I was getting ready to ask you.

A. Dr. Suarez, and then Dr. Motto.

Q. How do you spell that or how do you think you spell that?

A. M-O-T-T-O. He is my pain management doctor.

Q. Where is he?

A. Lexington.

Q. Lexington. Where?

A. Directly across the street from the hospital. I do not know his address off the top of my head.

Q. Do you remember the name of the practice?

A. Pain Management.

Q. Like Lexington Pain Management or --

A. No. Actually, I --

Q. Just Pain Management?

A. I'm pretty sure it's just Pain Management.

Q. Do you know his first name?

A. Doctor. That's pretty much all I've

ever heard him called by.

Q. Was it Dr. Odom?

A. That's the doctor in Irmo, yes.

Q. Who is Barnaby Dedmond?

A. That's the doctor who put my leg back -- he replaced a metal rod in my leg. The original surgery when they done it at Richland, the rod they stuck in my leg was bent or they installed it incorrectly and my foot was tilted so they had to go back in and straighten it out.

Q. When was that?

A. That was right around the time they done my hip. It was before -- I had my hip replaced October 5, '09, so that would have been June -- June or July of '09 that Dr. Dedmond would have done the lower part of my leg.

Q. I was looking at the list of doctors that you gave us when you responded to your discovery requests to see if there was anybody else that we should talk about. When did you start seeing Dr. Motto?

A. About a year and a half, maybe two years ago now. I don't remember the exact date. I got tired of dealing with Dr. Odom. He was -- he's a quack.

Q. He's a quack? Is that what you said?
A. Yes, ma'am. He likes to stick needles in people.
Q. Can you think of any other doctors that you've seen?
A. No, ma'am. I mean outside of a family physician, a family doctor that I went to a couple times over my ears.
Q. Who is that?
A. You know, I would have to get back to you on that. I do not know his name. I quit seeing my family doctor several years ago and I was going to try -- I've tried out different doctors to see if I would like them and I didn't much care for him so I never went back. But I only saw him once. But I have saw Dr. Lencke at Lexington -- I'm not sure exactly on the name of that place now. He's a neurologist. He was the one that done the MRI of my head to see if he could explain why my head was hurting.
Q. That was sometime at the beginning of this year or the end of last year?
A. Last year.
Q. Do you have a family doctor now?
A. I do not.

Q. You haven't found anybody you like?
A. (Shaking head.)
Q. Do you have a driver's license?
A. Yes, I do.
Q. South Carolina?
A. Yes.
Q. Do you have a commercial driver's license?
A. No.
Q. Do you have a motorcycle driver's license right now?
A. No.
Q. Have you had a problem with traffic violations in the past?
A. Just a couple of speeding tickets.
Q. Would you describe yourself as a safe driver?
A. Yes.
Q. Have you ever had any DUIs?
A. No.
Q. Have you ever been pulled for a suspected DUI but not ticketed before?
A. No.
Q. How would you describe your driving abilities?

A. Excellent.
Q. Had you ever wrecked a car in the past?
A. Yes.
Q. When?
A. I would say '90 -- yeah, probably around '95, '96. I backed into a gentleman at a gas station.
Q. At the pump?
A. No. Actually he came flying in through the exit side. So I was looking to the enter side, is the reason I never saw him.
Q. And you told me that a girl ran into you. When was that?
A. I would say probably a year prior to my accident. It might not have been quite that long. I honestly do not remember the date. She had damaged the back end of my truck. I was turning left from Mineral Springs actually going to a job site and she was just going too fast for the conditions.
MS. HORNE: Can we take a break for just a minute. Go off the record.
(A recess transpired.)
BY MS. HORNE:
Q. When did you start riding motorcycles?

A. I've rode motorcycles since I was eight years old.

Q. Do you ride ATVs?

A. Yes.

Q. Did you ever wreck one?

A. Not an ATV. No. Wait a minute. Yes, I did too. I'm going to say 2007, but it might have been 2006.

Q. Tell me about that.

A. I was just going too fast for conditions on the little trail and the front end of it hit a tree and caused me to break the hardest bone in the human body to break, actually.

Q. What bone is that?

A. The triangle bone that sits between your forefinger and your thumb. There's a little bone in there in the shape of a triangle. I cannot -- I don't remember the name of the bone itself, but that's the hardest bone in the human body to break. That's what the guy at Lexington Orthopaedics told me, anyway, when he bandaged my hand up.

Q. I'm sure you were very proud.

A. Oh, yeah.

Q. Had you been drinking?

A. No. That happened early Sunday morning, actually.

Q. Where did it happen?

A. In Fairfield.

Q. At that camp we were just talking about?

A. Correct. It was just loose dirt there. When I turned the wheel to go the dirt just kind of let me slide off the trail. I was just going too fast and not paying attention to what I was doing.

Q. When did you buy your first motorcycle?

A. When did I buy my first motorcycle? You know, I honestly could not give you a date. I've owned dirt bikes pretty much my entire life.

Q. When did you get your first dirt bike?

A. When I was eight.

Q. For your birthday?

A. No. My dad just brought one home one day, actually.

Q. Do you remember the first motorcycle you ever had?

A. Uh-huh.

Q. What was it?

A. It was a mini-bike. It's what they call a mini-bike. It was an 80 cc dirt bike

basically.

Q. How long did you have that?

A. Until we moved to South Carolina.

Q. When you were 14?

A. Correct.

Q. What other motorcycles have you owned?

A. I owned an XR 250 R. It's a Honda. I bought it -- I'd been working for a couple years at that time, so that would have around '93. And I owned it until it was stolen out of my backyard probably five years later.

Q. What else?

A. I went from that to -- I bought my Harley from the gentleman down the street from me. That was a Sportster. I think it was a 1200 or -- I don't recall off the top of my head. I bought it in -- I want to say right around 2002, 2003 maybe. And then I just owned different bikes after that.

I owned a Suzuki 1400 Intruder. I bought it new from the Suzuki place. I'm going to say that was 2004. And then I bought the Harley that I wrecked in 2005. It might have been 2006 before I got that Harley.

Q. Where did you get it?

A. From one of the superintendents that

I'd done work for with Mungo. His name is Tony Zimmen.

Q. How do you spell Zimmen?

A. Z-I-M-M-E-N.

Q. And you think you bought it in 2005 or 2006?

A. Yes, ma'am. It was one of those two years I'm sure.

Q. How often would you ride?

A. Through the summertime, twice -- two, maybe three times a week.

Q. For your whole life?

A. Not. Actually, when I first started my business I went the better part of ten years without riding. Just didn't have time.

Q. So when did you start riding regularly, that two or three times a week?

A. Probably in '07. When I say riding regularly I just mean I would get off of work, come home and just ride for two -- I say two or three hours. For 30, 40 minutes down the road and back just to clear my head before I went in.

Q. So the other motorcycles that you owned, the Honda and the Harley from 2002 and that Suzuki, you -- how often did you use those?

A. Well, the Honda was just -- like I said, it was a dirt bike so obviously I would have to take it somewhere to ride it. And I would say throughout the summertime probably twice a month I would ride the dirt bike.

The Intruder -- the Suzuki Intruder I bought, I didn't ride it that often. I didn't much care for it. It wasn't as comfortable as it was when I first rode it. You know, probably twice a month is about all I even rode it. Then I sold it to one of the guys that worked for me. When I sold that to him then me and him kind of started riding together.

Q. And you sold that at the same time that you bought that new Harley?

A. No. It was about eight months later. I would just let him ride it because I kept the insurance and tags on it. So he would just ride it.

Q. Did you have a motorcycle license?

A. I had a permit. I didn't have -- I haven't went and took the license part of it yet.

Q. What are the restrictions -- the differences between a permit and a license?

A. I really don't think there is any.

Q. Can you drive at night with a permit?

A. Yes. At least I assume so. I don't know. I don't know that I ever checked, to be honest with you.

Q. How would you describe your motorcycle driving abilities?

A. Excellent. Never had an accident until this one. It always confuses me here. In Tennessee a motorcycle license is not required. Your driver's license will you allow you to drive up to 26,000 pounds, and obviously a motorcycle weighs less than 26,000 pounds. So you can just drive. So here that permit and the license thing, that just -- I never really thought about it.

Q. Did you ever have a Tennessee driver's license?

A. Yes.

Q. When did you have a Tennessee driver's license?

A. Well, I would have to go back and check and see. I don't remember the years or the dates when I had them.

Q. Since you've lived in South Carolina have you had a Tennessee driver's license?

A. I think so, yes.

Q. Do you remember when?

A. No, ma'am. Like I said, I'll have to go back and check. That's been years ago.

Q. I think --

A. Years ago.

Q. I'm trying to remember. You moved to South Carolina as a teenager?

A. Correct.

Q. Have you always had a South Carolina driver's license?

A. Not always. I mean, like I said, there was a point in time that I was moving back to Tennessee. So I had to change my license over that weekend when I got up there.

Q. When did you live in Tennessee?

A. Again, I would have to -- it's been years ago. I do not recall the year or date off the top of my head. I'll have to get back to you on that. It was just for, actually, less than a week.

Q. It was less than a week?

A. Yeah.

Q. Were you a teenager?

A. No. Actually, I was married.

Q. And you moved to Tennessee for one

week?

A. Yeah.

Q. But you changed your address and license?

A. Just my driver's license. I actually done it while I was up there.

Q. And then you came back?

A. Correct.

Q. How familiar with the Harley that you wrecked were you?

A. Very familiar.

Q. Was it in good condition?

A. Yes.

Q. Everything was working?

A. Yes.

Q. Have you ever had any other wrecks?

A. I was involved in an automobile accident. I was 21 -- 20 or 21. And that wreck actually happened in Tennessee. And I was cited for being at fault at that wreck. Apparently you're just supposed to know that there was a stop sign there. There was no stop sign there.

Q. You didn't see it or there was not a sign?

A. There was no sign. There is now, but

there wasn't when the accident happened. That's funny. She was from Ohio. She had an Ohio tag on that car. I was in a 1985 Ford Ranger that I owned at the time. She T-boned the side of my truck.

Q. You were crossing an intersection?

A. I wouldn't call it an intersection. I was turning left onto a road. But apparently the road I was on was supposed to have stopped, but not that road. Trust me. It's very confusing.

Q. Any other wrecks?

A. Not that I can think of, no.

Q. Okay. Let's go back to the day of your motorcycle wreck. Do you remember the date?

A. June 18th.

Q. What year?

A. '08.

Q. What day of the week was it? Do you remember?

A. A Wednesday, if I recall.

Q. Tell me what you had been doing that day.

A. We had worked up to about -- I think we knocked off that day around 3:00, 3:30.

Q. What did do you that day at work?

A. Same thing I do every day, install

vinyl siding. We had knocked off and gotten -- I got home right around 4:00. I went and rode my bike for a couple hours. I stopped at a place called Carolina Wings to have a drink and grab a bite to eat and wound up getting suckered into playing a game of golf with J.R.

Q. What's golf?

A. It's a video game.

Q. Who is J.R.?

A. A guy I knew from that particular bar, slash, restaurant.

Q. What else had you done that day?

A. That was pretty much it.

Q. What time did you wake up?

A. Same time I always wake up, about 4 o'clock.

Q. Do you remember the job you were working on that day?

A. The actual street? The actual address of the job, no, I do not.

Q. Do you remember anything else about work that day?

A. I mean it was uneventful. It was just a house, as far as I'm concerned.

Q. Do you remember what neighborhood it

was in?

A. Brookhaven. I do remember the neighborhood, just not the house.

Q. Where is Brookhaven?

A. Northeast Columbia.

Q. I recognize that name. I can't place where it is.

A. It's in -- they have since named that conjunction of neighborhoods there. During that time it didn't have a name. I cannot recall it. You know how the Summit has all different types of neighborhoods in it? That subdivision is the same way. It's a long street that's got different neighborhoods going down it off of each side.

Q. Do you remember the street -- the big street?

A. No, not off the top of my head. I do not.

Q. Had you been anyplace other than your house and at work before you got on your motorcycle that day?

A. I'm sure I would have stopped by a gas station and gotten a soft drink or something, but not that I recall.

Q. Who else was with you that day?

A. When?

Q. Before you got on your motorcycle.

A. Before I got on my motorcycle everyone at work that day would have been around me at some point in time. Do you want their names?

Q. Do you remember any of their names?

A. I remember all their names.

Q. Well, yes, please.

A. Let's start with the Cullen brothers, B.J. and Sammy. They're my two half brothers. They were both there. Sammy Collins and his brother Shawn Collins were working that day. Sam Cox, Russell Carter, Joey Holmes, and Jacque Kenzler.

Q. How do you spell Kenzler?

A. I do not know. I mean I would assume it's K-E-N-Z-L-E-R, but I do not know.

Q. Anybody else you can remember working with that day?

A. Mike Candle would have been there that day as well. How many is that?

Q. Nine.

A. Steve Perry. I really can't think of the rest of them off the top of my head.

Q. That's okay. Did you have breakfast

that day?

A. No, ma'am. I don't eat breakfast.

Q. Did you eat lunch that day?

A. No, ma'am. I don't eat lunch either.

Q. Ever?

A. Not when I'm working I don't. Too hot. Weighs me down.

Q. I don't skip breakfast or lunch. Did you have dinner that day?

A. Yeah. I had eaten a sandwich before I left the house.

Q. What did you have?

A. A baloney sandwich.

Q. Anything else?

A. No. That was it. I would have either had a glass of tea or a glass or water with it while I ate my sandwich.

Q. Before you got on your motorcycle had you had any drinks that day?

A. Alcoholic?

Q. Yes.

A. No.

Q. Had you done any drugs that day?

A. No.

Q. Had you taken any medications that day?

A. No.
Q. Did you have a prescription for Zantac?
A. I don't think a prescription is needed for Zantac. It's an over-the-counter drug, ain't it?
Q. I don't know if it was then. Did you take any Zantac that day?
A. No.
Q. Did you take any other prescriptions that day?
A. No.
Q. Any other medications?
A. No.
Q. Aspirin? Pain medicine?
A. No.
Q. So you finished work at around 3:30. Then tell me more about what you did after work.
A. Like I said, just drove home. I ate a sandwich and decided it was a beautiful day and just went for a ride. I rode around. I honestly don't know that I could even tell you exactly where I went. I mean I would have came down through -- considering I wound up at Carolina Wings to grab a bite to eat that day -- Wednesday is the day that -- this would have been right after my

father-in-law had passed away and my wife and her sister always took Wednesdays to go to his house to sort of start going through the stuff, to throw out what needed to be trashed and then decide who was going to get what so eventually they could sell the house. So on Wednesdays I was typically on my own for dinner so I just went by Carolina Wings to grab a bite to eat.

Q. What time do you think you left the house?

A. What time did I leave my house?

Q. Uh-huh.

A. It would have been between 4:00 and 4:30 because I know traffic hadn't started getting real bad yet. Like I said, I rode around for about an hour, an hour and a half or so. Just riding through the city.

Q. Do you remember at all where you went?

A. No. I mean as far as directions, no. I mean I would have just came down 378 -- not 378 -- 302 and Highway 321, down that way, and just kind of zigzagging down around the city streets just looking around.

Q. Were you riding with anybody?

A. No. My sidekick for the day had

decided he was -- he had something else he had to do.

Q. Who did you usually ride with? I don't remember.

A. Jacque.

Q. Jacque. Kenzler? What's his last name?

A. Kenzler. Actually, now that I say that, that's not right. It's Kiser. His last is Kiser, not Kenzler.

Q. K-I-S-E-R?

A. I would assume that that would be correct.

Q. He's one of your friends from work, though?

A. Correct. He's one of the subcontractors that's done work for me for years.

Q. When did you decide to go to Carolina Wings?

A. I honestly couldn't tell you what time it was. I mean I would assume it would have been around 5:30 or going to toward 6:00, or maybe not even quite that late maybe. It might have been closer to 5:00. I just kind of zigzagged my way back and forth until I got there.

Q. Where is it located?

A. On Highway 1 near I-26.

Q. Did you go there regularly?

A. Yeah. That was a regular spot that we went.

Q. How often do you think you went?

A. Probably every other day between me going there to grab food and whenever I take my guys out after work. Because we never stopped to eat lunch. That would be what we would do after work. When we got off of work we would go to either there or Wild Hare for me to buy them lunch or buy them a drink, cool off, let them tell me how they felt that day, what can we go different, what can we do better, and just to keep everybody happy and keep things going. So, yeah, we was always there.

Q. Do you have friends there at the restaurant?

A. Yeah. I mean there was one of the young ladies that worked there that -- I mean I even cosigned for her to get her first car.

Q. What's her name?

A. Jessica Brown. But she was really the only one that I would say that I was friendly with.

The rest of them just worked there.

Q. Did you have any other people who were also regulars there who you knew, not employees?

A. Yeah. J.R., the gentleman I met the day of the accident. He was someone that I knew from there. He worked for the military.

Q. You met him the day of the accident or you saw him there on the day of the accident?

A. He was there, yes.

Q. Okay. How long had you known J.R.?

A. I'd say eight months to a year at least.

Q. What's his last name?

A. I do not know. I've actually thought about that and for some reason I keep wanting to say Smith. But that's my sister's last name. I don't know why I keep thinking it's Smith.

Q. That's what's jumping into your brain?

A. Yeah.

Q. If you think about it or if you remember it, tell us.

A. I will.

Q. How do you drive to get to Carolina Wings from your house?

A. From my house, direct route -- there's

two ways, actually. You can take I-26 to Highway 1 or you can take 321 down to -- I do not know the name of the street there in front of the K-Mart in Cayce, but you can turn left at the K-Mart in Cayce and that road takes you straight out to it as well.

Q. Did you usually take your motorcycle?

A. No. Generally I had my truck. It was -- because generally when I was there, like I said, I had my crew with me and we was just on our way home from work and we would stop either there or Carolina Wings (sic), just depending on which side of the city we were working on that day. We would just always stop in. It just depended on what I had that particular day.

That particular day we hadn't finished the house that we started so my crew didn't get to go, unfortunately. Had we finished the house we wouldn't even be here because I would have had my truck.

Q. About what time did you go to Carolina Wings? I think you told me that a second ago, but --

A. Yes, ma'am. It was between 5:00 and 6:00. I mean I didn't look at a clock. I was off work and I knew I had until about -- well, my wife

typically got home around 8 o'clock, 8:00, 8:30. So I had an hour or two before I had to worry about her coming home.

Q. Were you with anybody else at the bar?

A. Not that I recall, no. I mean I'm sure there were other people there, but I don't know that I knew their names.

Q. Were you talking to anybody specifically?

A. Just J.R.

Q. Was Jessica Brown there that night?

A. No.

Q. What did you do while you were at Carolina Wings?

A. Played the video golf game.

Q. Did you do anything else?

A. No.

Q. Where did you sit?

A. In a chair.

Q. I mean do you have a usual spot?

A. On the -- well, that place is actually closed down now, but yeah, the far end of the bar. Right by the golf game is where it was at.

Q. That's where your usual spot was?

A. Right. That's typically the only spot

you can sit. You get 10 or 12 guys, they don't want you out in the middle of the floor blocking the register so they always stick you at the corner.

Q. Did you sit at the bar or at a table that night?

A. I don't really know that I sat anywhere. I was kind of standing up along the edge of the machine. I've never been one for sitting very long. So typically I would stand no matter where I was at.

Q. Did you play that golf game a lot?

A. Oh, yeah.

Q. Were you good at it?

A. Not as good as J.R., but yeah, I was decent.

Q. What did you order?

A. Well, I had a Crown and Coke. I honestly don't remember what J.R. ordered. He was having a bad day so I bought him a couple of drinks that day. I'm trying to think of the bartender's name. I know she didn't like me. I know that much. I know my wife remembers her name, but I cannot think of it off the top of my head.

Q. Did you order any food while you were

there?

A. No, actually, I didn't. I never got around to it. I got interested in that golf game.

Q. You didn't eat anything while you were there?

A. No. I just figured I'd grab something when I got home.

Q. You mentioned that you drank a Crown and Coke. What other drinks did you have while you were there?

A. I actually had two of those. I didn't quite finish the second one, but I don't guess that much counts. I'd had two Crown and Cokes.

Q. Anything else?

A. No.

Q. Do you remember the time or how much time between the drinks?

A. Well, that golf game, when two people are playing it takes about an hour. So I would figure about an hour.

Q. So you think you had those two drinks over about an hour?

A. Hour, hour and a half, yeah.

(DFT. EXH. 3, Carolina Wings & Ribhouse receipt, was marked for identification.)

BY MS. HORNE:

Q. What time do you think you left the restaurant?

A. It was just after 8:00.

Q. This document has been marked as Defendant's Exhibit Number 3. Take a look at that. What's this document?

A. It looks like a receipt from Carolina Wings to me.

Q. Is this the receipt that you produced in your discovery responses?

A. Looks like it, yeah.

Q. Will you read the drinks that are on this receipt?

A. Bud Light bottle, Crown Royal, Southern Comfort, Crown Royal, Jager and Crown Royal.

Q. Is Jager listed twice on here?

A. It is.

Q. Okay. Did you buy these drinks?

A. Apparently I did. I can assure you I didn't drink them.

Q. Who did?

A. It had to have been J.R. I don't drink Jager. Jager or Grand Marnier is out.

Q. There are three Crown drinks on here.

Do you think you ordered three Crown drinks?

A. I only remember the two, but it says I ordered three, so -- I sure don't remember drinking that third one. I think the bartender might have been adding it to me.

Q. What about the Southern Comfort?

A. That was definitely J.R.

Q. What about the Bud Light?

A. J.R. I don't drink beer. That 2057, what is that? That's military time, correct?

Q. Uh-huh.

A. What time is that?

Q. 8:57, I think.

A. Okay.

Q. Do you think you might have gotten there and started ordering drinks at 8 o'clock?

A. Did I get there at 8 o'clock?

Q. When do you think you started ordering drinks?

A. I would have ordered a drink as soon as I got there.

Q. What time?

A. That would have been around 5:30.

Q. Okay.

A. Or a little after 5:00. I can't say

exactly. Like I said, I didn't look at a clock.

Q. So when I look at that receipt it looks like the tab got opened at 2001. Do you see that at the top? So that would be 8:01.

A. Yeah, I see that.

Q. But you think you started ordering drinks before that?

A. I know I did. I didn't leave my house at 8 o'clock. Now, I mean the bartender will write on a little tab what you got and then check it in when they get around to it. They don't do it every time. So, yeah, I mean I know I didn't get there at no 8 o'clock. It was well before that.

Q. Do you remember when you asked for the check and told them you were ready to head out?

A. Yes, ma'am. I remember.

Q. What time was that?

A. There's no clocks in there so I couldn't tell you.

Q. The stamp on this receipt says 2040 next to the total. Do you see that?

A. Yes.

Q. Do you think that maybe they prepared this total for you at 8:40?

A. It sounds right.

Q. Did you do anything between the time you paid your tab and left the bar?

A. I would have just talked to J.R. for a few more minutes before I headed out.

Q. What were your drinking habits like before this motorcycle wreck?

A. Regarding as far as what, how many and how often?

Q. Yeah.

A. I mean we would have -- like I said, whenever me and the guys would finish a house in a day's time we would go the nearest place and, you know, have a drink and talk about the how the day went. So, yeah, I mean I would have a drink, if not -- I'm not going to say every day because a lot of those times I wasn't even there. So I would say probably three times a week that we would go and have a -- you know, we would go and have a couple drinks.

Q. A drink or two three times a week?

A. Yeah, something like that.

Q. So would you describe yourself as a heavy drinker or a social drinker?

A. I wouldn't say either.

Q. Well, how would you describe yourself?

A. Well, yeah, I guess you would call -- social would be I guess what they would say it is.

Q. Had your drinking habits always been this way? Was there ever a time that they were different?

A. No, because throughout the wintertime we very rarely even get to go because we don't do a house in a day. So that's part of the reward for working so hard, was me taking them out for lunch, which winds up being late lunch for us because we never stopped to eat lunch. We'd work straight through lunch and then work until the house was done, if that was obtainable for that day.

Q. Had you ever been a heavy drinker?

A. No.

Q. Do you keep alcohol in your house?

A. I'm trying to think if there's any there now. I mean typically you would find a bottle of liquor at my house somewhere I'm sure. I've not drank probably three times since the accident.

Q. Well, before the accident did you only drink when you were out with your guys at these bars?

A. Yeah. I never drank when I came home.

Q. You said that you don't drink beer and you don't drink Jager. What would you generally drink?

A. Either Crown or Jack. I don't much drink anything else.

Q. How do you ordinarily order your drinks? How did you ordinarily order your drinks?

A. I don't understand the question.

Q. I mean you had Crown and Coke you said this night. Is that the way that you would order --

A. Yeah, that's typically how.

Q. Jack and Coke or Crown and Coke?

A. Correct.

Q. Not shots?

A. No.

Q. How many drinks a week did you usually have?

A. I would say two or three two or three times a week. So probably nine.

Q. Two or three drinks at a time two or three times a week?

A. Correct.

Q. I want to make sure I understood what you said. Are there other bars that you ordinarily

go to? You said Carolina Wings and Wild Hare.

A. Yeah. Those were the main two because that's the only two we could get our work truck and trailer into. You've got to have a big parking lot in order for my trucks to fit in. I have a F-550 that I pull a 32-foot enclosed trailer behind.

Q. That's a big truck.

A. Yeah. So you've got to have a big parking lot.

Q. But you were never a heavy drinker?

A. No. I mean I wouldn't classify it as heavy. I mean I didn't go out and drink until 3 o'clock in the morning.

Q. Did your drinking ever get you in trouble or cause problems?

A. No.

Q. No. What happened New Year's Eve 2008?

A. I'm sorry. New Year's Eve when?

Q. The New Year's Eve that rang in the year 2008.

A. I don't even remember, to be honest with you.

(DFT. EXH. 4, Lexington Family Practice record, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Defendant's Exhibit Number 4. It's a medical record from Lexington Family Practice in White Knoll. What happened that caused you to go to the doctor?

A. My wife pushed me backward into my recliner, and it's got a rocker -- it's a rocking chair of sorts. So when the legs picked up it stabbed me in my back and cracked one of my ribs.

Q. It cracked one of your ribs?

A. Uh-huh. The crack never showed up on the x-ray, but for a month and a half I couldn't breathe. So it was cracked. Trust me. They call it a hairline fracture.

Q. Did your drinking that night have anything to do with the injury that you got?

A. I'm sure it did. Typically my wife doesn't push me around. We were wrestling.

Q. How many drinks had you had that night?

A. Honestly, I could not say. That's been four years ago.

Q. Did you get pain medicine for that injury?

A. I don't recall, but again, I don't

remember. Again, that's four years ago. I don't think I did. Not for a cracked rib. I wouldn't think they would give you pain medicine, but ...

Q. It looks like they wrote you a prescription for Percocet. Do you remember if you got that filled?

A. If the doctor wrote it I'm sure I did, but it couldn't have been but for just a week or two, a week or two supply.

Q. You think you probably took those and then --

A. I would think so. If the doctor prescribed it I took it, yes.

Q. Was it for very long?

A. Like I said, it couldn't have been but just for a week or two because I can remember just a couple weeks after that still hunched over trying to breathe.

Q. Had you ever before the wreck that we're talking about today had too much to drink and then driven a car or motorcycle or any other vehicle?

A. No.

Q. Have you ever used or taken any drugs like marijuana?

A. No.

Q. Cocaine?

A. No. I ain't never seen cocaine. Actually, outside of marijuana I've never seen any other illegal drug.

Q. You've never done marijuana?

A. I didn't say I've never done it. I just said I don't take it.

Q. What's the difference?

A. Because when I was a teenager I would have tried it, as any teenager did, but I don't take it now, nor did I during the time that I had the accident.

Q. You hadn't taken any?

A. No.

Q. Okay. Back to the day of the accident. Take us from the time that you closed your tab at Carolina Wings until the time of the motorcycle crash.

A. I got on Highway 1, rode about three-quarters of a mile up the road, got on the off ramp -- excuse me -- got on the on ramp and got on I-26 and was heading home.

Q. Where did the wreck happen?

A. Right at the start of the off ramp to

Exit 115.

Q. Where were you going?

A. Home.

Q. You weren't going to stop anywhere else on the way?

A. No.

Q. How did you usually go home from Carolina Wings?

A. Either that route or up Platt Springs Road.

Q. Were you familiar with the ramp where the accident happened?

A. Yes. Yeah. I've taken it every day for 20 years, so I'm quite familiar with it.

Q. Where on the exit ramp did the wreck happen?

A. Right where the first curve starts in to the right.

Q. Were you wearing a helmet?

A. No.

Q. Do you usually wear a helmet with your bike?

A. No.

Q. Do you ever?

A. No.

Q. Were you wearing a leather jacket?
A. No.
Q. Do you usually?
A. No.
Q. Were you wearing sunglasses?
A. Yes.
Q. Tell me about that. Do you usually drive your motorcycle at night with sunglasses on?
A. Well, they're not sunglasses per se. They're just shaded to keep the glare off the road. They're not -- I mean they're not dark sunglasses, if that's what you're trying to get at.
My vision had nothing to do with the accident. The fact that a woman stopped in the middle of the off ramp to pick up a cell phone had everything to do with it.
Q. Where did your motorcycle strike her car?
A. In the back.
Q. Where in the back?
A. A little off to the right. That's really all I can remember.
Q. Just a little bit?
A. Yeah. A little from dead center of the car to the right. I had tried to go around her,

but just didn't have the time. And from there I could not tell you what happened. All I remember after that is waking up and sitting upright and looking at my leg bent in an L.

Q. What part of the car did the motorcycle hit?

A. The bumper.

Q. Close to the center, but off to the right?

A. Yes. If memory serves me correctly. Now, again, I've not seen the car since. I honestly could not say.

Q. Did you see her car on the ramp?

A. I'm sorry. Rephrase the question. Did I see the car? Well, obviously I saw the car. It's a car.

Q. Did you drive through the grass on your motorcycle?

A. No.

Q. You said that you were trying to go around her. Tell me about that.

A. When I first saw her hit her brakes I assume it was just to slow down to take the curve ahead, but she wasn't slowing down. She was coming to a complete stop. By the time I differentiated

the two, from her not slowing down but coming to a complete stop, I had tried to go to the right because that's the way my motorcycle was already leaning. I was getting ready to take the curve to the right. Therefore I tried to lean harder to go around her, but it was just too late. There wasn't enough room.

Q. Were her brake lights on?

A. Yes.

Q. Why didn't notice that she was stopping?

A. Because, again, I've taken that off ramp a thousand times. It's a curve. It's not a stop sign. There's no reason to stop there.

Q. Was the exit ramp safe?

A. Yeah. It's -- I've never been in no other accidents on it, so I would assume so.

Q. Is there anything about that exist ramp where the accident happened that's unusual?

A. No. The same as it's always been.

Q. Was it poorly constructed?

A. No. It's fine.

Q. What was the weather like?

A. It was a mild evening. It had been in the high 90s that day. So it was low 90s, upper

80s I'm sure.

Q. Was it dark?

A. No. Not all the way, no. It was -- the sun was just starting to go down.

Q. About how many times do you think you'd driven on that exit before the wreck?

A. Five days a week for 20 years. So you do the math on that one.

Q. Twice a day?

A. A lot. No. Just once. I only go home once.

Q. Do you remember anything else? You were describing seeing your leg. Was that at the accident scene?

A. Yes. That was after -- when I'd -- after the accident I came to. As I -- when I sat up my leg was like that. It was an L. And it wasn't my foot turning that way. It was my leg. So I knew then that I had a problem. So I called my wife and told her that I'd been involved in an accident.

Q. You called her when?

A. Sitting on the interstate while I was waiting on the police to show up, and the ambulance. Which I didn't care much about the

police. I wanted the ambulance to show up.

Q. What did you tell the people who were at the accident scene about what was going on?

A. I don't know that I told them anything.

Q. Do you remember anything?

A. I remember the ambulance people finally showing up. I faded -- apparently I thumped my head pretty hard because I faded in and out. I remember after I talked to my wife -- I remember there being a gap between that time and when I saw the ambulance. It was as though I blacked -- you know, if I fainted back out or, you know, something. I can't explain that. It seemed like it took forever for the ambulance to get there, though.

Q. Other than talking to your wife do you remember talking to anybody else before you got in the ambulance?

A. No. I mean I know I would have talked to the -- I don't think the lady that caused the accident actually -- I don't think I talked to her, but I remember speaking with a gentleman. But, again, I don't know that he was -- I think he was just a passerby, someone who had stopped to see if they could help.

Q. Do you remember what you said?
A. No.
Q. Do you remember what you told your wife?
A. Yeah.
Q. What did you say?
A. I told her she was right. She always said I was going to get in an accident and break my leg on a stupid motorcycle. And ironically she was right.
Q. Wives have a tendency to know these things. What else did you tell her?
A. I told her that my leg was broke and that I loved her and I'm probably going to the hospital. At that time I didn't even know my hip was broke. All I knew was that my lower -- I knew my lower leg was broke, but I didn't know my hip was broke. Shattered, actually. Broke and shattered.
Q. Do you remember anything in the ambulance?
A. Not really. I mean nothing stood out for me to remember. I just remember being in a lot of pain.
Q. Do you remember anything once you got

to the hospital?

A. Not really. I just, again, remember being in a lot of pain, arguing with the -- well, actually, I do remember arguing with the police to get the hell out the way so the doctors could do their job.

Q. When did you talk to the police?

A. At the hospital.

Q. Did you get a ticket?

A. Yeah. Actually, I did.

Q. What did you get ticketed for?

A. DUI.

Q. Anything else?

A. Yeah. Not having a motorcycle license. Apparently my permit had expired and I didn't know it. That's so retarded, though. A driver's license rates you to drive a 26,000 pound truck, but it doesn't rate you to drive a 500 pound motorcycle. That just seems odd to me.

Q. You said that you talked to the police. Tell me about what you discussed with the police at the hospital.

A. Honestly, I couldn't tell you. All I can remember is getting really angry because he was holding the doctors up from doing their job and I

almost lost my foot on account of it. So, yeah, I was a little upset with him.

Q. What kind of treatment did you get at the hospital?

A. Actually, Lexington Medical Center didn't -- that's where they took me directly after the accident. I was there for three days and didn't get any treatment.

Q. Nothing?

A. They straightened the -- they straightened my leg out, but they couldn't put anything together. The surgeon that worked for Lexington was on vacation that week.

Q. So what happened?

A. I sat there for four days in traction and then they moved to me to Richland, where I sat for another two or three days in traction before they finally found a surgeon who could do the surgery.

I think the swelling -- I think they had to wait for the swelling to go down. I don't think it was necessarily that they were waiting to find a surgeon. It was the swelling had to go down before the surgeon could do it. So either way I was in a lot of pain.

Q. When did you go home from the hospital?
A. You know, I do not remember the date. I'm wanting to say it was right at three weeks after the accident. It might be a little shorter than that or a little longer than that. I don't recall.
Q. Were you involved in a lawsuit with the other driver?
A. No.
Q. You didn't sue her?
A. No. She had state minimum insurance coverage. There was no reason to sue her, or at least that's what my attorney said at the time.
MS. HORNE: Can we take a break for a second.
(A recess transpired.)
(DFT. EXH. 5, Transcription of Magistrate's Court Hearing, was marked for identification.)
BY MS. HORNE:
Q. This document has been marked as Defendant's Exhibit Number 5. Tell me about the criminal trial for the DUI charge and the driving with an expired license charge.
A. Well, the driving with expired license

charge, obviously I had done that so I paid the fine. The DUI charge was thrown out as well.

Q. What happened at court?

A. The prosecutors didn't have none of their witnesses there for my lawyer to talk to, I guess. I don't know. The judge threw it out.

Q. Were you there in court that day?

A. Yes.

Q. Was there a trial by jury that acquitted you of the DUI charge?

A. No. Actually, the jury never got called in.

Q. Did the judge look at the facts of the case and rule that you weren't intoxicated?

A. You would have to ask the judge what he looked at. I have no idea what he looked at.

Q. Did he rule that you were not intoxicated?

A. He ruled that I was not guilty, so I would assume so. Honestly, you would have to talk to him.

Q. Did your lawyer make a motion to dismiss because the right person wasn't there to testify?

A. I think that's what happened, but you

would have to talk to the lawyer.

Q. So your case was dismissed?

A. Yes. Dismissed, thrown out, whatever they call it.

Q. What do you think caused you to run into Mrs. Collins's car that night, the other driver's car that night?

A. The fact she slammed on her brakes and stopped on an off ramp had something to do with it.

Q. Where was she stopped?

A. On the off ramp.

Q. What part of the off ramp?

A. Right before you get to the curve.

Q. Where was her car in the road?

A. In the middle of the road.

Q. It was in the very middle of the road?

A. Well, thereabouts, yes.

Q. Have you talked to anybody other than your attorney about the cause of the wreck?

A. No. I'm sure me and my wife have discussed it, but ...

Q. Were you buzzed when you left Carolina Wings?

A. I don't believe so, no.

Q. Were you feeling the effects of

alcohol?

A. Not that I can recall, no.

Q. The hospital lab reports indicate that you had an elevated blood alcohol reading. Are you aware of that?

A. Yes, I am. And that's the reason I fought it, because there's just no way my blood alcohol was that high. They either made a mistake during their testing or some of the drugs that they had given me in the ambulance was affecting it. I can't explain why it came out to be that high, but I was not intoxicated when that wreck happened.

Q. Do you think alcohol had anything to do with causing the wreck?

A. No, I do not. Her stopping on an off ramp a thousand feet from the stop sign had something to do with the cause of the accident. And as she told the police -- I wasn't there when she told the police that she had -- she told the police there that she had dropped her cell phone and that's why she stopped. At least that's what I was told. I don't know how true that is. I honestly do not know.

Q. Since the night of the wreck have you spoken with the police at all about their

investigation?

A. No.

Q. Have you talked to anybody at SLED?

A. No.

Q. What did they --

A. At least I don't think I have.

Q. Who told you about the conversation that she had with the police?

A. If I'm not mistaken, the police had told my wife that, but I'd have to verify that with my wife.

Q. Did the police ask you about your drinking that night?

A. He had asked me if I had been drinking and I told him, yes, I had been. And that's the reason why he wanted to do the blood test. I was like, well, fine, go ahead. Just get out of the doctor's way so they can fix my leg before I lose it.

Q. So you consented to the SLED blood draw?

A. Yes. Again, I wasn't drunk so I had nothing to worry about.

Q. Do you know that the SLED toxicology report shows that you had an elevated blood alcohol

level?

A. Yes. You've already asked me that question.

Q. There are two separate reports, one from the hospital lab and one from SLED. Did you know that the SLED intoxication report showed that you had a blood alcohol level that was elevated?

A. No. I don't know that I ever knew there was -- the only one I ever knew about was the one from the hospital. Again, this was four years ago so I could have very well known of both of them then and I just don't remember now too. It's just not something that I'm concerned with.

Q. Are you aware of a lawsuit that was filed named Michael Russell versus Connie Collins in Lexington?

A. No.

Q. You're not aware of that lawsuit?

A. Actually, I take that back. I remember having a brief conversation with one of the gentlemen that works for Farm Bureau. I do not know his name. He had basically asked me if she was injured during the accident. And I couldn't imagine how she would have been injured so I said no. So -- but I don't know that he told me there

was a lawsuit, but he very well could have. Again, that was four years ago.

Q. Did you initiate a lawsuit against her?

A. No.

Q. Did your wife initiate a lawsuit against her?

A. Not that I recall, no.

Q. Were you involved in a lawsuit in which you were represented by someone -- by Robert Brown or Richard Harpootlian involving Connie Collins, the other driver?

A. Richland Harpootlian. That was the name of my attorney during the DUI charge. As far as I can remember, all he done was go fight the DUI charge. I don't know any of lawsuit that he placed against anybody.

Q. What about a lawsuit in which you were represented by Carey Ayer that was filed with your name as a plaintiff against Connie Collins, the other driver?

A. I don't even know Connie -- what did you say her name was?

Q. Connie Collins.

A. I don't even know that name.

Q. You did not initiate a lawsuit against

her?

A. Not that I recall, no. As I remember, if I remember correctly, once the DUI charge was dismissed I had spoke with my attorney later that week and he basically told me that she had state minimum coverage and that she basically owns nothing so there's really no reason to even try to sue her because you're not going to get anything, it would be a complete waste of time. So as far as I know, he didn't.

MR. RILEY: Let's go off the record for a second.

(Off-the-record conference.)

BY MS. HORNE:

Q. Did Connie Collins or her insurance company pay you any money after this wreck?

A. No.

Q. Did your insurance company pay her any money?

A. You would have to ask my insurance company.

Q. You're not aware of any settlement between your insurance company and Connie Collins?

A. I am not. I pay the yearly fee that they charge me for insurance and they do their own

little thing.

Q. Are you aware that Connie Collins received a settlement --

A. No.

Q. -- because of the lawsuit that you initiated against her?

A. No, I'm not. Again, I have not had -- my insurance company has told me nothing of their agreements or settlements with a third party.

Q. Are you aware that there is a lawsuit in which Michael Russell and -- I don't have the document in front of me, but I believe also Susanne Russell sued Connie Collins for injuries.

A. Again, I was under the impression from my attorney, Harpootlian, that he was not going to do that. Now, if he done it and I just forgot about it, then so be it, but I do not recall that being the case at all.

Q. For the record, the civil matter number that we're discussing is 2008-CP-32-03411, Michael Russell, et al., versus Connie Collins.

Were you ever represented by McWhirter, Bellinger & Associates in any capacity following this wreck?

A. Not that I'm aware of, no.

Q. Okay. Did your car or motorcycle insurance premiums go up after the wreck?

A. I don't know. Again, I'm married to a CPA. She paid the bill, not me.

Q. Do you still have a motorcycle?

A. No.

Q. Did you get collision coverage for damage to your motorcycle?

A. No. I don't understand the question. Did I have --

Q. Did you get a payment for damage to the bike?

A. Yes, they paid.

Q. Your insurance company paid?

A. Yes. They paid me for what the motorcycle was valued at.

Q. Did the other driver's insurance company pay anything?

A. Not that I'm aware of, but again, I do not know the answer to that question.

Q. Have you been involved in any other civil lawsuits?

A. No.

(DFT. EXH. 6, Court file that relates to Case Number 08-CP-32-3411 entitled Michael

Russell and Susanne Russell, Plaintiffs, versus Connie Collins, Defendant, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Defendant's Exhibit Number 6. This document is the court file from the Lexington County Courthouse that relates to Case Number 08-CP-32-3411 entitled Michael Russell and Susanne Russell, Plaintiffs, versus Connie Collins. Is that -- you have no memory of asking your attorneys to file this lawsuit?

A. No. Actually, I don't. Well, apparently nothing came of it. Why are we talking about it?

Q. Do you think your lawyers filed this lawsuit without your permission?

A. I can't imagine my lawyer doing that, no. I just -- as I said, that's four years ago. I just forgot about it.

Q. Do you know that in this lawsuit Connie Collins asserted counterclaims against you?

A. No, I did not.

Q. Are you aware that there was a settlement between the parties?

A. Again, the answer is no.
Q. And you did not receive any payment from Connie Collins or her insurance company?
A. No.
Q. When did you notify Penn Life about the motorcycle wreck?
A. I believe it was on day nine after the accident.
Q. Were you still in the hospital?
A. Yes.
Q. How did you notify them?
A. I would assume I called them. Again, that was four years ago. I have no memory whatsoever of contacting them after that accident.
Q. Do you think you called or your wife called?
A. I would assume my wife called because during the ninth day after that accident I was just barely out traction.
Q. But you remember it was the ninth day?
A. That sounds right, for some reason. I know it was after seven.
Q. What did you tell them?
A. Honestly, if I told you anything I would be lying because I do not remember.

Q. What information or documents did you provide to Penn Life?

A. Whatever information they required to start the disability policy. I mean you're expecting me to remember something that happened four years ago. Actually, over four years ago this has been.

Is it okay if I stand for a minute?

Q. Yes. Please.

Did you give Penn Life the accident report, the collision report?

A. If it was required then I'm sure I did. Honestly, I don't know the answer to any of those questions. It was just too long ago for me to try to remember what I would have or did not give them. I mean that's too long of a span.

(DFT. EXH. 7, Accident report, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Defendant's Exhibit Number 7. Did you provide this document to Penn Life? I know it's not a great copy. I have another one.

A. I started to say, this is a copy of what I sent to them, it looks like, yes. It's not

the one I sent them. The one I sent them wouldn't have been that distorted.

MS. HORNE: Let's try this one.

(DFT. EXH. 8, Accident report, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Exhibit Number 8. It's a slightly different copy of the same form. Do you think that this is the form that you --

A. It appears to be, yes.

Q. Is that the accident report?

A. Yes, it appears to be it.

Q. Does it have information about what happened in the accident on it?

A. Not that I can read, no.

(DFT. EXH. 9, Accident report, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Exhibit Number 9. Is this the collision report?

A. That's what it says.

Q. Did you submit this form to Penn Life?

A. Again, if it was a requirement that they had then, yes, I would have, but do I remember

specifically submitting this, no, I don't.

Q. When you made your claim on your disability policy with Penn Life did you indicate anywhere on the claim form that you'd been charged with DUI?

A. I do not know. I do not know that that's a requirement on their claims form. So, again, if it was required for me to give them then I gave it to them.

Q. Did the collision form that we're looking at right now indicate that you were charged with DUI?

A. Not that I see on there, no.

Q. On the second page that's marked PLIC 412, at the bottom of the page it says in the last section of the form, contributing factors, driver, and the number 16 is listed. The number 16 refers to the notation under the influence. Do you -- is that correct?

A. I'm not seeing it on my page.

Q. (Indicating.)

A. It's not in quotations on this one.

Q. In the box that says primary in the far left column do you see a number entered there?

A. Yes.

Q. What number is entered there?
A. Sixteen.
Q. What does that notation correspond to in the contributing factors --
A. I suppose that's supposed to be under the influence, but it's hard to read. You'll make my headache ten times worse trying to read that small ass writing right there.
Q. Do you want me to change this blind?
A. No. That's fine.
Q. In the notes that are on the first page of the traffic collision report form, at the bottom next to the picture of the accident scene can you read what the trooper has written there starting with Unit 1 and Unit Number 2.
A. I don't see where you're referring to. Eastbound on I-26 exit ramp to U.S. 321. Unit 2 stopped on the side of the -- sorry. That doesn't say --
Q. That's okay.
A. -- rear corner, still in the roadway. Unit 1 driver under the influence. Struck Unit 2 in the right rear.
(DFT. EXH. 10, Statement, was marked for identification.)

BY MS. HORNE:

Q. This document has been marked as Exhibit Number 10.

A. Okay.

Q. The last page of the packet is stamped 372. It's a Fedex shipping label.

A. That's what it appears to be.

Q. Does it show that this package was sent to Penn Life by Susanne Russell?

A. Yes, that's what it looks like.

Q. Do you think that this is the packet of information that you sent to Penn Life when you made your claim?

A. Again, I would have to say yes, but again, that's four years ago. I could not say for certain.

Q. Is the collision report form included in these documents?

A. I'm going to assume so since you've asked the question.

Q. The policyholder's claim report that's stamped PLIC 370 at the bottom, did you fill out that form?

A. I'm sorry. Say that again.

Q. Page 370, it's sort of midway through

the packet. Do you see that page?

A. Yes.

Q. It's called the policyholder's claim report. Did you fill out this form?

A. Yes.

Q. Is that your handwriting?

A. Yes. Actually, no. That's not my handwriting.

Q. Whose handwriting is it?

A. That's my wife's.

Q. That's your wife's handwriting?

A. Yeah. Too neat for mine. But that's my signature.

Q. At the bottom that's your signature?

A. Yes.

Q. There's a line that says, describe how it happened, about halfway through the form. It says, motorcycle accident. Below that it says, if this is a motor vehicle accident please include a copy of the police report.

A. Okay.

Q. Did you read this form?

A. I'm sure I did, but, again, that was four years ago.

Q. And you signed the form?

A. Yes. That was four years ago.
Q. Did you follow up to send any additional documents to Penn Life?
A. Again, if it was required, I did. If not, I did not.
Q. Okay. Did you ever tell anybody at Penn Life that you'd been charged with DUI?
A. If they asked, I did. I don't know that I just volunteered that information. That's right. No one from Penn Life will talk to you so I'm sure the answer was no to that.
Q. You had trouble communicating with Penn Life when you started to --
A. From the very beginning I had problems.
Q. Tell me about that.
A. You would call and you would get -- Ella Lee was my caseworker and she was never at her desk and she never would return a phone call.
Q. Did somebody from Penn Life come out to your house sometime in the fall of 2009?
A. I vaguely remember someone from Penn Life coming out there because that was right around the time that they really started not paying their monthly -- the monthly checks. It was an elderly gentleman, if I'm not mistaken.

Q. A man came out?

A. Yes.

(DFT. EXH. 11, Field Adjuster's Report, was marked for identification.)

BY MS. HORNE:

Q. That document has been marked as Defendant's Exhibit 11. It's the field adjuster's report from the gentleman who came to your house to talk to you.

A. Okay.

Q. When you met with him that day did you tell him that you'd been charged with DUI?

A. I'm sure by then I thought nothing about it. It was a year after. So, no.

Q. No, you did not?

A. I don't recall doing so, no.

Q. Did you talk to anybody -- when was the first time you talked to anybody at Penn Life about the fact that you'd been charged with a DUI?

A. I could not tell you a date or a time.

Q. Do you remember generally? Time of year?

A. No.

Q. Before or after the adjuster came out?

A. I do not.

MS. HORNE: You don't remember.

(DFT. EXH. 12, Phone Call Report, was marked for identification.)

BY MS. HORNE:

Q. This has been marked as Defendant's Exhibit Number 12. It's a phone call report form marked with a date of December 31, 2009. Take a second to review the notes that say, nature of the call. Do you remember this phone call?

A. No, I do not.

Q. You don't remember having that call with Ella Lee?

A. You expect me to remember a phone call from three years ago? Really? No, I do not. Now, I doubt -- I don't doubt that the phone call took place, but I do not remember it, no.

Q. Do you remember having any other conversations with anybody at Penn Life about the fact you were charged with DUI at the time of the accident?

A. I do not, no.

Q. No. Okay. And you don't remember this phone call?

A. No. Not to discuss it. No, I don't.

Q. What other communications with Penn

Life have you had up until the time that you hired your attorney for this matter?

A. There really was none to speak of. They would always say anytime I called the policy was under review, we'll get back to you, and they never got back to me.

Q. Is there anybody else with information or knowledge about the motorcycle wreck or about anything else involved in this case that we haven't talked about?

A. Not that I can think of, no.

Q. You think we've talked about all the potential witnesses or people who might have information?

A. Yeah.

Q. You can't think of anybody else?

A. Not off the top of my head, no.

Q. Okay. Do you have family in Lexington County?

A. I do.

Q. I'm going to ask you to give me their information because if this goes to court we'll want to make sure that we have a sense of who your family is before we draw a jury.

A. Okay. Well, I've already told you my

two half brothers, B.J. and Sam Cullen.

Q. Benjamin? Is that what you said?

A. B.J.

Q. Oh. B.J. I'm sorry.

A. Billy John is his real name. And the other one is Samuel Cullen, Junior. And then I have a younger sister, Amanda Smith.

Q. Is she married?

A. She is.

Q. What's her husband's name?

A. Timothy Smith.

Q. Do they have adult children?

A. They have one adult child.

Q. What's that child's name, if that child lives in Lexington County?

A. He does, but he's confined to a wheelchair. Tim Smith, Junior, actually is his name.

Q. Any other siblings?

A. No.

Q. Does Susanne have any siblings in Lexington County?

A. A sister.

Q. What's her name?

A. Stephanie Morvay.

Q. Can you spell that last name?
A. No.
Q. Morvay?
A. Morvay, yes. It's pretty much how it sounds.
Q. Does it end with a Z or an A-Y? Do you know?
A. I'm pretty sure it's A-Y.
Q. Any other aunts or uncles, cousins?
A. All of my family lives in Tennessee.
Q. So you don't have any other adult relatives in Lexington County?
A. Not in Lexington County, no. I do have an older sister, but she lives in Greenville.
Q. What is Stephanie Morvay's -- excuse me. Is she married? Is Stephanie Morvay married?
A. Yes.
Q. What's her husband's name?
A. Bob Morvay.
Q. Do they have adult children?
A. No.
Q. Let's take a look at Exhibit Number 9 again, the collision report form. What are the officers' names that are at the bottom of this form? In the very bottom below the illustration.

A. I can't read that writing.

Q. I'll tell you that it says W.C. Harmon and G.D. Rothell.

A. Rothell. Okay.

Q. Did you meet with two highway patrol officers at the hospital?

A. I remember the one. I don't remember the second one. I couldn't tell you which name went to which one. I never bothered. I was a little preoccupied.

Q. Did you see or speak to the officers at the accident scene where the wreck happened?

A. I don't think so. I think by then the ambulance had gotten to me. Before the officers got there the ambulance people were working on me. I know I spoke to them, gave them my driver's license and all of that, but honestly, I don't remember what was said.

Q. The drawing that is on this collision form shows Unit Number 2, which is the vehicle of the other driver, on the left side of the road.

A. She was not that far off the road. She moved the car after the accident.

Q. She moved the car after the accident?

A. Yeah.

Q. And your opinion is that this vehicle was located where before she moved it to the side of the road?

A. There was -- when I made contact with her car there was no part of her car off of the off ramp. She was completely in the off ramp when the accident occurred.

Q. And tell me again where your motorcycle hit her vehicle.

A. Well, that's got it showing like it barely -- like I barely caught the corner of her car. From dead center of her car I would say no more than a foot to a foot and a half toward the right side is where the indentation of my bike should be. Now, I mean, you know, you'd have to call her to find out because I haven't seen the car since and I didn't get up and walk behind the car after the accident either. I pretty much laid there.

Q. And it's your opinion that alcohol had nothing to do with causing this motorcycle wreck?

A. Absolutely not.

MS. HORNE: I don't have any further questions.

MR. RILEY: I have no questions.

(The deposition was concluded at 4:20 p.m.)

CERTIFICATE OF REPORTER

I, Angela D. Zuver, Court Reporter and Notary Public for the State of South Carolina at Large, do hereby certify that the foregoing transcript is a true, accurate, and complete record.

I further certify that I am neither related to nor counsel for any party to the cause pending or interested in the events thereof.

Witness my hand, I have hereunto affixed my official seal this 15th day of November, 2012 at Lexington, Lexington County, South Carolina.

Angela D. Zuver, Court Reporter
My Commission expires
July 2, 2014

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01 92:4
0145 30:1,8
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04 8:12 57:14
07 21:17 71:18
08 26:25 76:16
08cp323411 118:25 119:8 138:2
09 64:14,15

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10 43:17 49:4 88:1 124:24 125:3 138:9
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115 100:1
118 137:25
12 54:8 88:1 129:2 129:6 138:12
1200 70:15
121 138:6
122 138:7,8
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125 27:1
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129 138:12
13 42:21,24 43:3,8 43:17 137:7
1320 1:14 2:10
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14 6:2,14,19 12:11 70:4
1400 70:19
1463 8:21,24 21:2
1469 8:18,24,25
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15 6:5,24 32:1
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16 123:17,17
17 137:23 138:6,8
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20 39:6,6 55:10 75:18 100:14 104:7 135:2
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2012 1:11 136:13
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2057 91:9
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22 9:6 26:25
23 137:21
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26 73:11,12 107:17
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29172 5:14
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89 7:19 137:19

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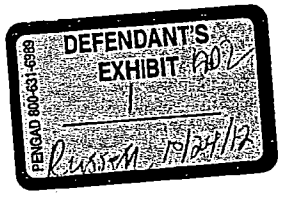
Russell v. Pennsylvania Life Insurance Company
Civil Action No. 2:10-cv-00816-MBS

Claimant Report Mailed	Documents Received	Benefit Check Date	Benefit Check No.	Check Amount
09/03/08	09/04/08	09/22/08	BD310325689	$ 8,125.00
10/03/08	10/07/08	10/29/08	4210002410	$ 2,500.00
11/10/08	11/12/08	11/14/08	4210005455	$ 2,500.00
12/12/08	12/17/08	12/23/08	4210008506	$ 2,500.00
faxed 01/28/09 mailed 01/29/09	01/28/09 02/04/09	02/11/09	4210013923	$ 5,000.00
03/11/09	03/13/09	03/16/09	4210016833	$ 2,500.00
04/06/09	04/08/09	04/10/09	4210019546	$ 2,500.00
05/05/09	05/08/09	05/20/09	4210022422	$ 2,500.00
06/22/09	06/24/09	07/06/09	4210027524	$ 2,500.00
08/11/09	08/13/09	09/08/09	4210033163	$ 5,000.00
09/24/09	09/28/09	10/09/09	4210035890	$ 2,500.00
10/22/09	10/27/09	11/13/09	4210038663	$ 2,500.00
12/03/09	12/08/09	01/12/10	4210043769	$ 5,000.00
01/26/10	01/28/10	02/12/10	4210046455	$ 5,000.00
03/01/10	03/05/10	03/15/10	4210049058	$ 2,500.00
				$ 53,125.00

Note 1: The benefit check dated 09/22/08 for $8,125 included two months of disability as well as surgical benefits and benefits for ambulance service, x-rays, and emergency first aid.

Note 2: This chart does not include benefit payments made after 03/15/10.

Note 3: There have been a total of 25 monthly periods between the date of the accident (plus the 7 day elimination period) and March 1, 2010 for which Mr. Russell has submitted proof of disability. The above chart reflects that a total of $50,000 of disability benefits have been paid (25 x $2,500 per month).



0809-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 2 MIKE RUSSELL

IMPORTANT 8050
1. Print Clearly & answer all questions
2. If you need additional room to complete a question, attach a sheet of paper.
3. SIGN BOTTOM OF FORM

AUGUST 14, 2008

CLAIMANT'S NAME: Michael C. Russell Soc.Sec.Num: [redacted]

Date of Birth: [redacted] Home Phone: Work Phone:

Are you receiving or applying for Worker's Compensation, Unemployment Compensation or other disability benefits? YES_____NO_✓_ ? If YES, please provide the name and address of the company(ies) and the policy number(s).

Employer Name: MCR Construction LLC Employer Address:

Occupation: Owner of Company-Construction Monthly Gross Earnings: $ 4300

Job Duties: Owner, vinyl siding application

Were you working before you became disabled? YES ✓ NO____ If NO, what were you doing?

If you are self-employed, is your business still operating? YES ✓ NO____ If NO, when did it stop?

When did you first receive medical treatment? 6-18-08 Where? Lexington Medical Center

What is the name and address of the doctor treating you? Dr Taquinto 3 Medical Park Columbia, SC. 29203

What is the name and address of any other doctors you have been referred to?

What is the name and address of your primary/family physician? Dr. Nagel 5535 Platt Springs Rd. Lexington SC 29073

If you were in the hospital, please give dates of confinement: Admitted 6-18-08 Discharged 7-1-08

Hospital: Lexington Medical Center Address: 3720 Jurget Blvd West Columbia SC 29169 3 Richland Medical Park Columbia SC. 29203

*(Include copy of hospital bill with this form)

Describe the sickness or injury Compound leg fracture, broken hip

If this is for a sickness condition, when did it first begin?

If this is an accident, when and where did it happen? Date: 6-18-08 Time: 9:20 PM Place: I-26 Exit 115

Describe how it happened. Motorcycle accident

IF THIS IS A MOTOR VEHICLE ACCIDENT, PLEASE INCLUDE A COPY OF THE POLICE REPORT.

Have you ever had a similar condition in the past? YES____NO ✓ IF YES, please give dates, a brief description and the name and address of the doctor who treated you.

IF EMPLOYED, did the condition above cause you to lose any time from work? YES ✓ NO____ If YES, provide dates.

First Day not worked 6-19-08 What duties were you unable to do? All

When were you able to do SOME of your duties? Date:_____ ALL of your duties? Date:

IF RETIRED, A HOUSEWIFE, STUDENT OR UNEMPLOYED, did the above condition prevent you from doing your normal daily activities? YES:____NO_____ If YES, provide dates. First Day unable to do activities

What activities were you unable to do?

When were you able to do SOME of your normal activities?

When were you able to do ALL of your normal activities?

Did this condition cause you to be confined? YES_____NO ✓ If YES, provide dates. FROM_____TO_____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Pennsylvania Life Insurance Company - PO Box 12355, Pensacola, FL 32591-2355

CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE - any medical professional, medical care institution, consumer reporting agency insurance institution, insurance support organization, institution source, governmental agency including, but not limited to, the Social Security Administration and the Veterans Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agency or legal representative, and any insurance support organization and consumer reporting agency acting on The Company's behalf, with any and all medical records and personal information, requested about me or any of my minor children.

I UNDERSTAND that this Authorization will be used to obtain, information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use OT drugs or alcohol. I UNDERSTAND the information obtained by the use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy. I KNOW that I or my legal representative may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I UNDERSTAND that the duration of the Authorization is for. The term of coverage of the policy under which a claim for benefits has been submitted. If this Authorization is given in connection with a claim for disability or life insurance benefits, I UNDERSTAND that is valid for the duration of the claim.

Mike Russell 8-27-08

SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE 1052C

PLIC 0001

Attending Physician's Report

PATIENT'S NAME: Richard Russell DOB:

1. DIAGNOSIS: (Please provide ICD Code) Primary 803.0 Secondary 823.30

2. Describe any other disease or infirmity affecting the present condition.	
3. When did symptoms first appear or accident happen?	DATE: 6·18·08
4. If accident, please describe.	motorcycle accident
5. When did this patient first consult you for this condition?	DATE: 6·18·08 TIME ____ AM ____ PM
6. Has patient ever had same or similar conditions? If YES, please state when and describe	Yes ___ No ✓
7. Please provide the name(s) and address(es) of any other treating physician(s)	
8. Provide the CPT code and date of any surgeries performed.	CPT CODE: 27759 DATE: 6·24·08 CPT CODE: 27226 DATE: 6·24·08
9. a. If hospitalized, give name and address of hospital & admission & discharge dates.	Hospital: Palmetto Richland Memorial Address 5 Medical Pk. Dr. City Columbia State SC Admitted 6·20·08 Discharged 7·1·08
b. If confined to a nursing facility, give name and address of the facility and admission and discharge dates.	Nursing Facility Address City State Admitted Discharged
10. Provide dates of treatment:	Office: 7/15/08, 8/11/08 Hospital: 6·20·08 - 7-01·08 Nursing Facility:
11. Is patient still under your care for this condition? If NO, give the date discharged from your care.	YES ✓ NO DATE:
12. How long was (or will) the patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	FROM: WJ date TO: UNDETERMINED
13. How long was (or will) the patient (be) partially disabled (able to perform some but not all of his/her occupational duties)?	FROM: same as above TO:
14. If retired, housewife, student or other non-employed, please indicate a reasonable period of recovery.	No activities FROM TO Partial activities FROM TO
15. Was house confinement necessary? If YES, give dates. (see definition of "confinement" below)	YES NO ✓ FROM TO

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

REMARKS

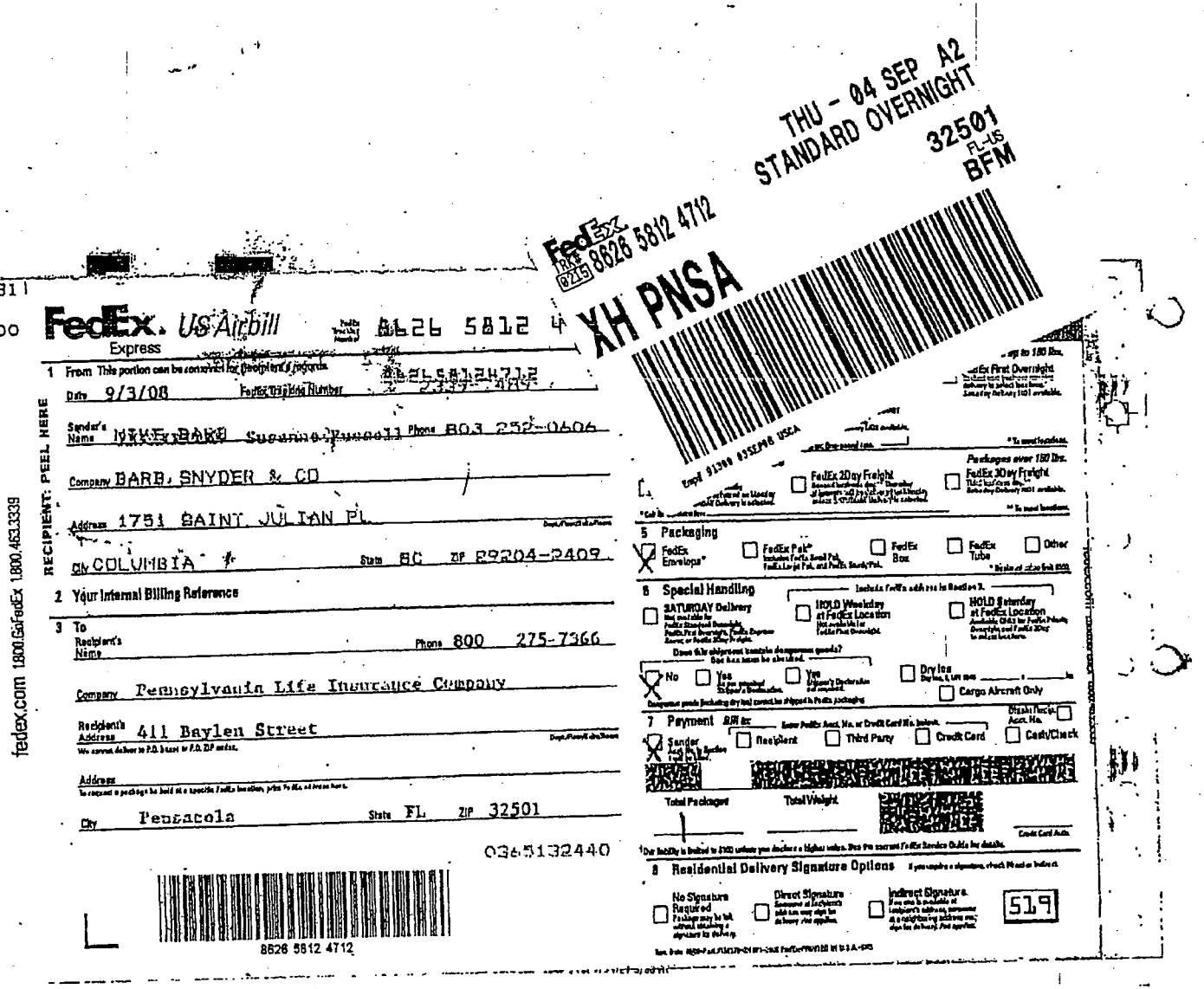
Name of Physician: (please print)
John Iaquinto
Address: 3 Med. Pk. Dr. Ste. 330
City: Columbia
State: SC Zip: 29203

Signature:
Date: 8/27/08 Tax ID #: 582296052
Telephone #: 803.434.6958
Fax #: 803.434.8537

THANK YOU – Your time is appreciated
Pennsylvania Life Insurance Company P. O. Box 12355, Pensacola, FL 32591-2355

1052C

PLIC 0002



811
00

FedEx. US Airbill Express 8626 5812 4

1 From This portion can be removed for recipient's records. 8626581247 12

Date 9/3/08 FedEx Tracking Number

Sender's Name [illegible] Phone 803 252-0606

Company BARR, SNYDER & CO

Address 1751 SAINT JULIAN PL

City COLUMBIA State SC ZIP 29204-2409

2 Your Internal Billing Reference

3 To Recipient's Name Phone 800 275-7366

Company Pennsylvania Life Insurance Company

Recipient's Address 411 Baylen Street

Address

City Pensacola State FL ZIP 32501

0365132440

8626 5812 4712

RECIPIENT: PEEL HERE

fedex.com 1.800.GoFedEx 1.800.463.3339

FedEx Trk# 8626 5812 4712

THU - 04 SEP A2
STANDARD OVERNIGHT
32501
FL-US
BFM

XH PNSA

Dept 91309 03SEPA6 USCA

FedEx First Overnight — Packages over 150 lbs.

FedEx 2Day Freight — FedEx 3Day Freight

5 Packaging

FedEx Envelope* FedEx Pak* FedEx Box FedEx Tube Other

6 Special Handling

SATURDAY Delivery

HOLD Weekday at FedEx Location

HOLD Saturday at FedEx Location

Does this shipment contain dangerous goods? No Yes Yes Dry Ice Cargo Aircraft Only

7 Payment Bill to: Sender Recipient Third Party Credit Card Cash/Check

Total Packages Total Weight

8 Residential Delivery Signature Options

No Signature Required Direct Signature Indirect Signature

519

PENNSYLVANIA LIFE INSURANCE CO.

September 4, 2008

Mike Russell

RE: **Policy No: [redacted]9360**
Claim No: 0809-00062

Dear Mr. Russell

We have received your claim for benefits.

This has been referred to our claim department. You will hear from them just as soon as they have had an opportunity to review your file.

If you have any questions please contact us at 1-800-ASKPENN.

Sincerely,

Pennsylvania Life Insurance Company
Claims Department

PO Box 12355, Pensacola, Florida 32591-2355 • (Tel) 1-800-275-7366 (Fax) 1-850-432-6077

PENNSYLVANIA LIFE INSURANCE COMPANY
ORLANDO, FLORIDA

BANK OF AMERICA

06-278
611

09-22-08 00310325689

CLAIM NO: 0809-00062 POLICY: [redacted]9360

$8,125.00

EIGHT THOUSAND ONE HUNDRED TWENTY-FIVEDOLLARS AND 00 CENTS

MIKE RUSSELL

CO

[redacted]

PLEASE RETAIN THIS VOUCHER AS YOUR PAYMENT RECORD

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 09-22-08
CLAIM NO. 0809-00062 CHECK NO. BD310325689

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			600.00
1901	70	TOTAL DISABILITY	06-25-08	08-25-08	2MO	2000M	4,000.00
		TOTAL DISABILITY	06-25-08	08-25-08	2MO	500M	1,000.00
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			2,400.00
1946	00	AMBULANCE	06-18-08	06-18-08			50.00
		X-RAY	06-18-08	06-18-08			25.00
		EMERGENCY FIRST AID	06-18-08	06-18-08			50.00
						TOTAL THIS PAYMENT	8,125.00
						TOTAL PAID TO DATE	8,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0005

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

8570

MAIL CENTER

OCT 07 2008

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Cell / Home / Work — Age: 36	Claim No: 02-001-001-080900062 Policy No: [redacted]9360
1. Describe the condition causing your disability: motorcycle accident - broken leg and broken pelvis	
2. What is the name and address of all physicians currently treating you?	John Iaquinto - Premier Orthopedic Specialists 3 Richland Medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	office visit 9-22-08
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, completing puzzles etc.

DATE: 10-3-08 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0006

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	S/p (L) acetabulum fx, grade 3A open (L) tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9/22/08
3a Next Appointment Date: 11.3.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? ~~UNDETERMINED~~ SAME	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NO	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 10/2/08 SIGNED:

ADDRESS: 3 Medical Plz. Dr. Ste. 330 TELEPHONE 803-434-6958
Columbia, SC 29203

C-3 R Rev. 3-96

PLIC 0007

ROA 1627

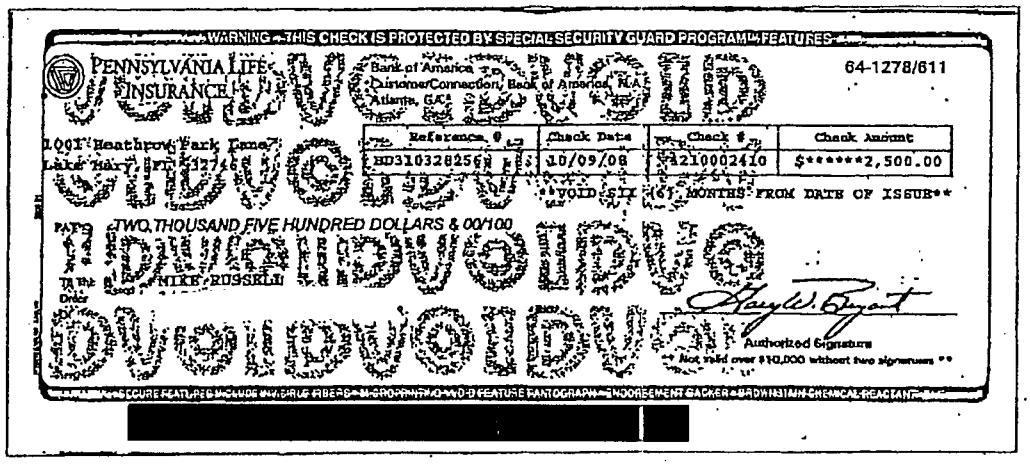
Russell

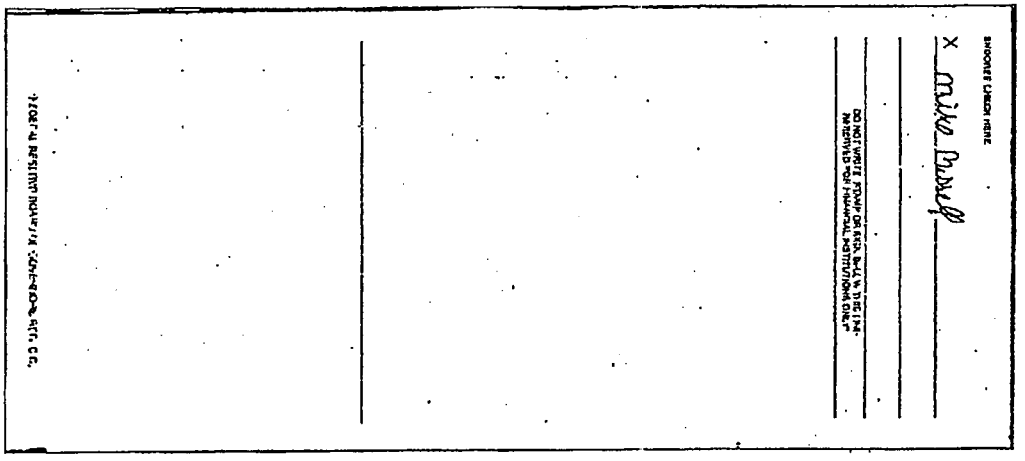
UNITED STATES POSTAGE
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MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0008





Location	Acct #	Check #	Amount	Paid Date	Sequence	Customer Data
CD	[redacted]	4210002410	$2,500.00	10/20/2008	3194484695	

R/T Number	CD VolID/CIMS Key	CD Label	Payee Name
6111278	08110340222101	08110340222101	

PLIC 0009

ROA 1628

(W) 850-0000 (Wife)

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
NOV 12 2008
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number cell / Home / ~~Work~~ / Age:	Claim No: 02-001-001-080900062 Policy No: [redacted]
1. Describe the conditions causing you disability.	bicycle accident - broken left hip
2. What is the name and address of all physicians currently treating you?	John Iaquinto - Premier Orthopedic Specialists Richland Medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	office visit 11-3-08
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill:)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 11-3-08 SIGNED: Mike Russell

ADDRESS:

C & P Rev. 4-97

PLIC 0010

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	4p ⓛ acetabulum fx, grade 3A open ⓡ tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9-22-08, 11-3-08
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? UNDETERMINED	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NOT SURE OF DATES	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11/6/08 SIGNED:

ADDRESS: PREMIER ORTHOPEDIC SPECIALISTS
3 MEDICAL PARK, SUITE 330
COLUMBIA, SC 29203

TELEPHONE 803-434-6958

PLIC 0011

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002787927 NOV 10 2006
MAILED FROM ZIP CODE 78204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

ROA 1631

PLIC 0012

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310331298	11/14/08	4210005455	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210005455
CHECK DATE 11/14/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-14-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310331298

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		13,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0013

330-0000 8090

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
DEC 17 2008
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / Cell / ~~Work~~ Age: 36	Claim No: 02-001-001-080900062 Policy No: [redacted]8360
1. Describe the conditions causing your disability. motorcycle accident- broken leg + hip	
2. What is the name and address of all physicians currently treating you?	John Iaquinto - Premier Orthopedic Specialists 3 Richland Medical Park Dr. Suite 330 Columbia, SC 29203
3. On what dates were you treated since completing your last report?	11-3-08
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 12908 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0014

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Acetabulum posterior wall fx/dislocation open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined as above
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 12/10/08 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803.434.6158
Columbia SC 29203

PLIC 0015

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 DEC 12 2008
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

325912355 B012

ROA 1635

PLIC 0016

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted] DATE PAID 12-23-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310334348

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-08	11-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-08	11-25-08	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		15,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0017

01-28-09;03:48PM;

Cathy Hale

8090

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Cell / ~~Home~~ / ~~Work~~	Age: 30
Claim No: 02-001-001-0B0900062	
Policy No: [redacted]9360	

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Iaquinto- Premier Ortho, 3 Richland Medical Park Dr. Ste 330 Colg, SC 29203
Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
11-3-08 Dr. Iaquinto
12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

RECEIVED
JAN 28 2009
DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: SIGNED:

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0018

01-28-09;03:48PM;

PENNSYLVANIA LIFE INSURANCE CO. NY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Dacetabulum posterior wall fx/dislocation open tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/28/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr Ste. 330 TELEPHONE 803 434 6458
Columbia, SC 29203

C-3 R

Rev. 3-98

PLIC 0019

ATTN: CLAIMS

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

FEB 04 2009

PENSACOLA

RECEIVED

FEB 04 2009

PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home / Cell / ~~Work~~	Age: 30	Claim No: 02-001-001-08090.0052 Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Ortho. 3[illegible] medical Park Dr. Suite 330 Cola, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063
3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital _____
   Address _____
   Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 1-28-09 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev. 4-97

PLIC 0020

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	(L) acetabulum posterior wall fx/dislocation Open (D) tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined
6. When did or will your patient be able to resume full work?	undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/29/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803 434. 6958
Columbia, SC

PLIC 0021

Russell

COLUMBIA SC 292
29 JAN 2009 PM 1 T



PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

ROA 1641

PLIC 0022

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310339762	02/11/09	4210013923	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210013923
CHECK DATE 02/11/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 02-11-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310339762

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-08	01-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-08	01-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		20,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0023

PENNSYLVANIA LIFE INSURANCE COMPANY

P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

MAR 13 2009

PENSACOLA

MIKE RUSSELL

Dependent Name

CLAIMANT'S REPORT

Telephone Number Home / Cell / ~~Work~~	Age: 36
Claim No: 02-001-001-080900062	
Policy No: [redacted]9360	

1. Describe the conditions causing your disability. motorcycle accident - broken leg + hip	RECEIVED MAR 13 2009 PENSACOLA DISABILITY CLAIMS
2. What is the name and address of all physicians currently treating you? John Faquino 3 Richland Medical Park Suite 330 Columbia, SC 29203	Dr. William Odom PO Box 1997 Elmo, SC 29063
3. On what dates were you treated since completing your last report?	Dr. Odom - Jan 19th, March Dr. Faquinto Feb [redacted]
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading etc.

DATE: 3-10-09 SIGNED: Mike Russell

ADDRESS: [redacted]

C-3 R Rev. 4-97

PLIC 0024

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, Fl. 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability. Degenerative Disease	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 3/2/09
3a Next Appointment Date: April 1, 2009	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

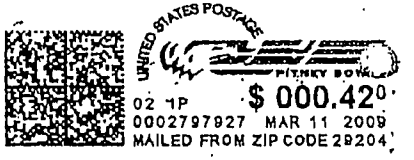
Must be furnished under authority of the law

DATE: 3/2/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-8585

PLIC 0025

Russell



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

ROA 1645

PLIC 0026

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310342678	03/16/09	4210016833	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 42100168
CHECK DATE 03/16/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 03-16-09
CLAIM NO. 0809-00062 REF ID. BD310342678

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-09	02-25-09	IMO	2000M	2,000.00
	TOTAL DISABILITY	01-25-09	02-25-09	IMO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	23,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0027

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

APR 08 2009

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Cell ~~Work~~	Age: 36
Claim No: 02-001-001-080900062	
Policy No: [redacted]360	

1. Describe the conditions causing your disability.	motorcycle accident - broken leg and hip
2. What is the name and address of all physicians currently treating you? Dr. William Odom PO Box 497 Elmo, SC 29063	Dr. Randall Suarez - Lexington Orthopedics 146 N. Hospital Drive Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - April 1 Dr. Suarez - march 17
4. Have you been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 4-6-09 SIGNED: Mike Russell

ADDRESS:

PLIC 0028

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 726.2	
2. Describe any other conditions contributing to present disability. Degenerative DZ	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: April 1, 2009
3a Next Appointment Date: April 29, 2009	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ ~~NO~~

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

[redacted]

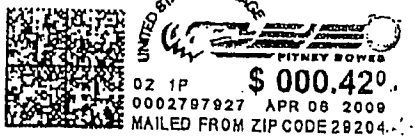
Must be furnished under authority of the law

DATE: 4/1/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-9585

PLIC 0029

Russell



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1649

PLIC 0030

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310345383	04/10/09	4210019546	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210019546
CHECK DATE 04/10/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 04-10-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310345383

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-09	03-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	02-25-09	03-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		25,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0031

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

8090

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
RECEIVED
MAY 08 2009
MAY 08 2009
PENSACOLA
DISABILITY CLAIMS

Mike Russell

Dependent Name

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ Cell	Age: 36
Claim No: 0809-00062	
Policy No: [redacted]9360	

1. Describe the conditions causing your disability.
   Motorcycle Wreck - broken leg + hip
2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington Orthopedic 146 D. Hospital Dr. Suite 140 West Columbia SC 29169
3. On what dates were you treated since completing your last report?
   Dr. Odom - April 29
   Dr. Suarez - April 21
   Dr. Dedmond - April 28
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   UNKNOWN
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, Completing exercises, reading, etc.

DATE: 4-29-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0032

PENNSYLVANIA LIFE INSURANCE COMPANY
EXECUTIVE OFFICES: P. O. Box 720, Buffalo, NY 14201-0720

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 4-29-09	Dates of treatment since last report: 4-29-09
3a Next Appointment Date: 5-28-09	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital NO Address Admitted:_____ Discharged_____
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 4-29-09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC TELEPHONE 803-749-8585

PLIC 0033

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 MAY 05 2009
MAILED FROM ZIP CODE 29204

Pennsylvania Life Insurance Co.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310348278	05/20/09	4210022422	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210022422
CHECK DATE 05/20/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 05-20-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310348278

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	03-25-09	04-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	03-25-09	04-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		28,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0035

8010

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
JUN 24 2009
RECEIVED
PENSACOLA JUN 24 2009
PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / Cell / Work	Age:
Claim No: 02-001-001-080900062	
Policy No: [redacted]9360	

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Juarez + Dr. Dedmond - Lexington Ortho pedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - May 28
   Dr. Dedmond - May 8 (surgery) + May 20

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Outpatient Surgery - Exchange Nailing (L) Tibia with Fibular Osteotomy
   Hospital: Lexington Medical Center
   Address: West Columbia, SC 29169
   Admitted: 5-8-09 Discharged: 5-8-09

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, Completing Exercises, reading, etc.

DATE: 6-15-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0036

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, Fl. 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80	Closed Fracture Tibia
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care. 4/28/09 5/26/09 6/15/09	Dates of treatment since last report:
3a Next Appointment Date: 7-8-09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unable to tell next eval 7-8-09	
6. When did or will your patient be able to resume full work? Unable to tell next eval 7-8-09	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 6/15/09 SIGNED:

ADDRESS: 146 North Hospital Dr. Ste. Col A S.C. 29169 TELEPHONE 803-936-7230

PLIC 0037

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT N...	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
50809	DEDMOND MD	REPAIR TIBIA	MIKE	2,188.00		
		AMOUNT APPLIED TO DEDUCTIBLE: $619.29				
		Insurance Balance: 1,319.48		Patient Balance:		868.52
50809	DEDMOND MD	INCISION FIBULA	MIKE	947.00		
		Insurance Balance: 883.55		Patient Balance:		63.45

...lement
...te: 05/21/09

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: [redacted]

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
3,135.00	0.00	0.00	0.00	3,135.00	2,203.03	931.97

...NDING PAYMENTS TO:
LEXINGTON ORTHOPAEDICS
...46 N HOSPITAL DR BTE 140
WEST COLUMBIA, SC 29169
803-935-9683

...0581*725291*0000582.000582 0000708001 920065902

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

92065S1

PLIC 0038

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 JUN 22 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591X2355

ROA 1658

PLIC 0039

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310353355	07/06/09	4210027524	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210027524
CHECK DATE 07/06/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-06-09
CLAIM NO. 0809-00062 REF ID. BD310353355

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	04-25-09	05-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	04-25-09	05-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	30,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0040

PENNSYLVANIA LIFE INSURANCE COMPANY
P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
AUG 13 2009
PENSACOLA

MITZY RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / Cell / ~~Work~~	Age: 37
Claim No: 02-001-001-080900062	
Policy No: [redacted]9360	

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom- June 25
Dr. Dedmond July 8

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
Out patient Surgery - exchange nailing (L) Tibia w/ Fibular Osteotomy
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 5-8-09 Discharged 5-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing exercises, reading, etc.

DATE: 7-29-09 SIGNED: Mitzy Russell

ADDRESS: [redacted]

C-3 R Rev. 4-97

PLIC 0041

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80 808.0	Closed fracture unspecified tibia Acetabular Fracture
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 5/8/09	Dates of treatment since last report:
3a Next Appointment Date: 8/26/09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unknown	
6. When did or will your patient be able to resume full work? Unknown	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[X] YES [ ] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Pt underwent surgery on 5/8/09 for a left tibial nonunion

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/09 SIGNED:

ADDRESS: 146 N. Hospital Dr. W. Columbia, SC 29169 TELEPHONE 803-936-7230

PLIC 0042

YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs. We have received your payment. Please pay the balance in full or contact Customer Service for any questions regarding this bill.

10237-P655

▶ SUMMARY OF CHARGES

250 PHARMACY GENERAL	682.00
258 PHARMACY IV SOLUTIONS	130.00
259 PHARMACY OTHER	10.25
270 MS SUPPLY GENERAL	518.00
272 MS SUPPLY STERILE SUPPLY	5866.21
278 MS OTHER IMPLANTS	27716.50
300 LABORATORY GENERAL	13.00
301 LABORATORY IMMUNOLOGY	90.00
305 HEMATOLOGY	226.00
306 BACTERIOLOGY/MICROBIO	336.00
314 CYTOPATHOLOGY/HISTOLOGY	220.00
320 RADIOLOGY DIAG GENERAL	925.00
350 DR SVCS GENERAL	3023.00
370 ANESTHESIA GENERAL	1575.00
636 DRUGS SPEC ID DETAIL CODING	91.00
710 RECOVERY ROOM GENERAL	1010.00
964 PROF FEES ANESTHETISTS RNA	6600.00
Billed charges to date:	51303.96



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

PAGE: 1 of 1

0101

MICHAEL C RUSSELL

[redacted]

▶ INSURANCE INFORMATION

BLUE CHOICE/COMPANION 2ZU30241197

▶ QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST?
CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT
(803) 936-7000 OR (877) 865-9972, MONDAY-FRIDAY,
8:30 AM TO 5:00 PM. SEE BACK FOR MORE INFORMATION.

▶ ACCOUNT SUMMARY

Statement Date:	06/25/09
Patient Name:	MICHAEL C RUSSELL
Date of Service:	05/08/09
Account Number:	[redacted]
Total Charges:	51303.96
Insurance Payments Received:	-30141.91
Adjustments to Insurance:	-18663.53
Patient Payments Received:	-35.00
This is your balance:	2483.42

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
07/10/2009	06/25/09	[redacted]

AMOUNT DUE	SHOW AMOUNT PAID HERE
2483.42	$

6517478

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P655*TDN0JIBBU000148

[redacted]

PLIC 0043

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002787927 AUG 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1663

PLIC 0044

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 09-08-09
CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0045

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
SEP 28 2009
PENSACOLA

MIKE RUSSELL

Dependent Name

~~CLAIMANT'S REPORT~~

Telephone Number Home / ~~Work~~ / Cell	Age: 37
Claim No: 02-001-001-080900062	
Policy No: [redacted]936D	

1. Describe the conditions causing your disability.
motorcycle accident- broken leg and hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Desmond - Lexington Orthopedic 140 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Mom - Aug. 25
Dr. Desmond + Suarez Aug. 26

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

RECEIVED
SEP 28 2009
PENSACOLA DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 9-23-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0046

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition.
   ICD Code: 823.80, 823.81
   996.4
   → Closed fracture of tibia
   Closed fracture of fibula
   mechaniacl compl. of internal orthopaedic device

2. Describe any other conditions contributing to present disability: see above

3. Describe dates of treatment since last report and indicate if patient is still under your care. yes
   7/8/09 8/26/09
   Dates of treatment since last report: 8/26/09, 7/8/09 &

3a Next Appointment Date: 9/29- Dr. Suarez
   10/26/09- Dr. Dedmond
   Patient discharged on: no

4. Has the patient been confined to a hospital since completing your last report?
   no
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. When did or will your patient be able to resume some work or activity?
   unable to determine - re-eval on 10/26 with Dr. Dedmond - for leg surgery on 10/5/09 w/Dr. Suarez for hip

6. When did or will your patient be able to resume full work?
   unable to determine

7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined.
   (See definition of CONFINEMENT below.)
   ☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

patient being treated by Dr. Barnaby Dedmond for his left tibia/fibula fracture and will be evaluated and treated by Dr. Randall Suarez for his hip.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/18/09 SIGNED: BDedmond

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive
Suite 140
West Columbia, SC 29169

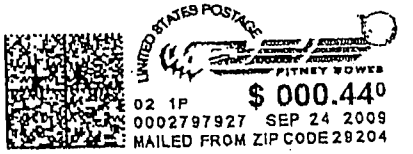
TELEPHONE 803-936-7230

C-3 R

Rev. 3-96

PLIC 0047

Russell



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1667
PLIC 0048

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 10-09-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310361735

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0049

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

RECEIVED
OCT 27 2009
PENSACOLA DISABILITY CLAIMS

MAIL CENTER
OCT 27 2009
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ Cell	Age: 37
	Claim No: 02-001-001-080900062
	Policy No: [redacted]360

1. Describe the conditions causing your disability:	motorcycle accident- broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Redmond- Lexington Orthopedics 1460 W. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report? Dr. Odom Aug. 25	Dr. Redmond Aug. 26 Dr. Suarez Sept. 29
4. Have you been confined to a hospital since completing your last report? Yes (If "YES", give date of confinement and attach a copy of your hospital bill.) have not received bill yet	Hospital Lexington Medical Center Address West Columbia, SC 29169 Admitted: 10-5-09 Discharged 10-8-09
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☑ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 10-27-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0050

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	733.42
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09 Dr. DeSimone 9/24/09 - Dr. Suarez 10/5/09 - Dr. Suarez (Surgery) 10-29-09 Suarez
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: Lexington Medical Center Address 2720 Sunset Blvd Admitted: 10-5-09 Discharged 10-8-09
5. When did or will your patient be able to resume some work or activity?	Approx: 1-5-10
6. When did or will your patient be able to resume full work?	Approx 1-5-10
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

DATE: 10-20-09 SIGNED: [signature]

ADDRESS: TELEPHONE

C-3 R Rev. 3-96

PLIC 0051

ROA 1671

Russell



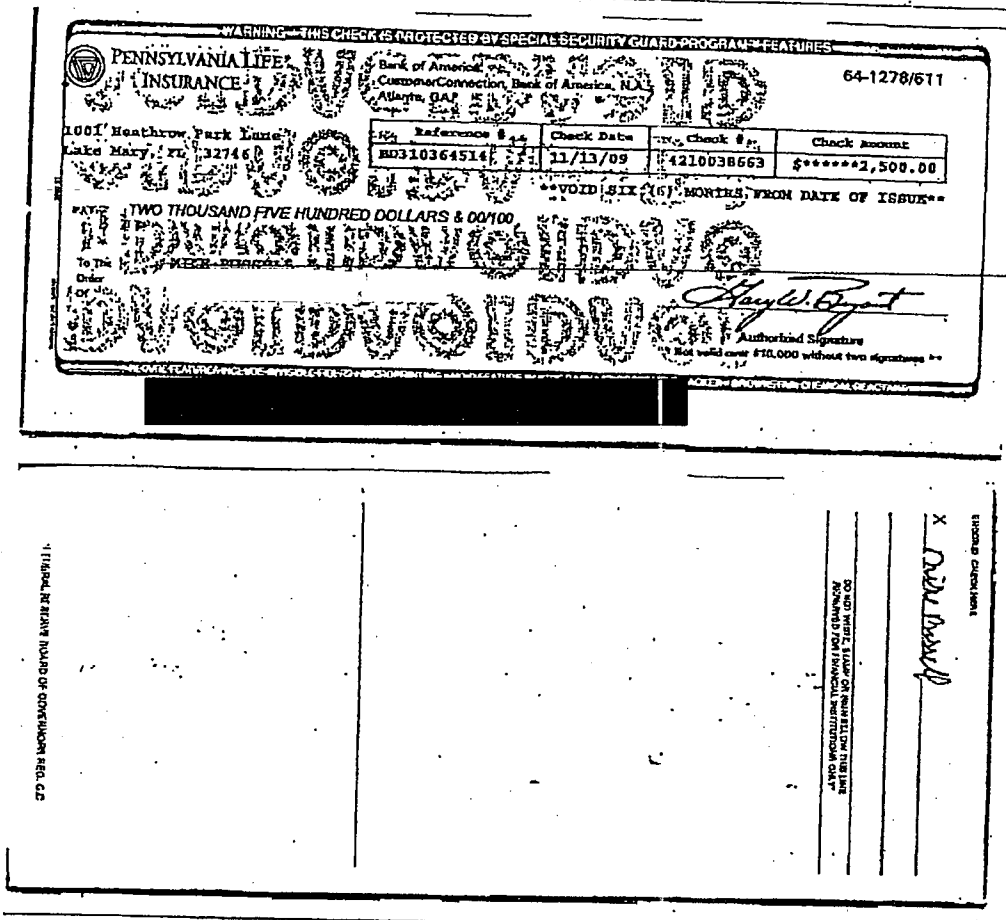
PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0052

Document type : Disbursement Check

06/03/2010 12:10 PM



Tag	Note	Item Date	Sequence Number	Account Number
Routing Number	Amount	Serial Number	Image Indicator	Sorry Indicator
Customer Data	Payee Name	Volume ID	Account Name	Issue Date
No	No	11/20/2009	2394675855	[redacted]
6111278	2500.00	4210038663	1	0
		09120100077101		

Bank of America

Page 1/1

PLIC 0053

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 08 2009

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ Cell	Age: 37
	Claim No: 02-001-001-080900062
	Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident- broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Desmond- Lexington Ortho. 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report? Dr. Odom- Oct 26	Dr. Desmond Oct. 26 Dr. Suarez Oct. 29, Nov. 10
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☑ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 12-2-09 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev. 4-97

PLIC 0054

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Tib/Fib - fx - Iddings
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09, 10-29-09, 11-10-09
3a Next Appointment Date:	Patient discharged on: No
4. Has the patient been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11-30-09 SIGNED: Randall S. Young, MD

ADDRESS: Lexington Orthopaedics
~~146 N. Hospital Drive, Ste 140~~
West Columbia, SC 29169
(803) 936-7[illegible]

TELEPHONE _____

C-3 R

Rev. 3-96

PLIC 0055

Russell



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1675

PLIC 0056

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 01-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		45,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0057

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER JAN 28 2010 PENSACOLA

MIKE RUSSELL

2[redacted] Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ Cell	Age: 37
Claim No: 02-001-001-080900062	Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg and hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - 1-18-10 / Dr. Suarez - 12-17-09
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Working TV, completing exercises, reading, etc.

DATE: 1-25-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0058

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/p (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/p (L) tkb / fib rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 12-17-09
3a Next Appointment Date: 1-28-10	Patient discharged on: —
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/20/10 SIGNED: Randall S Stuart, M.D.

ADDRESS: Lexington Orthopaedics 146 N. Hospital Drive, Ste.140 West Columbia, SC 29169 (803) 936-7230 TELEPHONE

C-3 R

Rev. 3-96

PLIC 0059



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0060

ROA 1679

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]0360 DATE PAID 02-12-10
CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0061

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2010
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / Cell / Work	Age: 37
Claim No: 02-001-001-080900062	Policy No: [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Redmond - Lexington Orthopedics 1460 D. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - 1-18-10 / Dr. Suarez - 2-25-10
4. Have you been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital / Address / Admitted: / Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: / Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 3-1-10 SIGNED: Mike Russell

ADDRESS: [redacted]

C-3 R. Rev. 4-97

PLIC 0062

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) total hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) hip/groin rehab
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 1/28/10, 2/25/10
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2-25-10 SIGNED: Randall S. Burg, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

TELEPHONE

C-3 R

Rev. 3-96

PLIC 0063

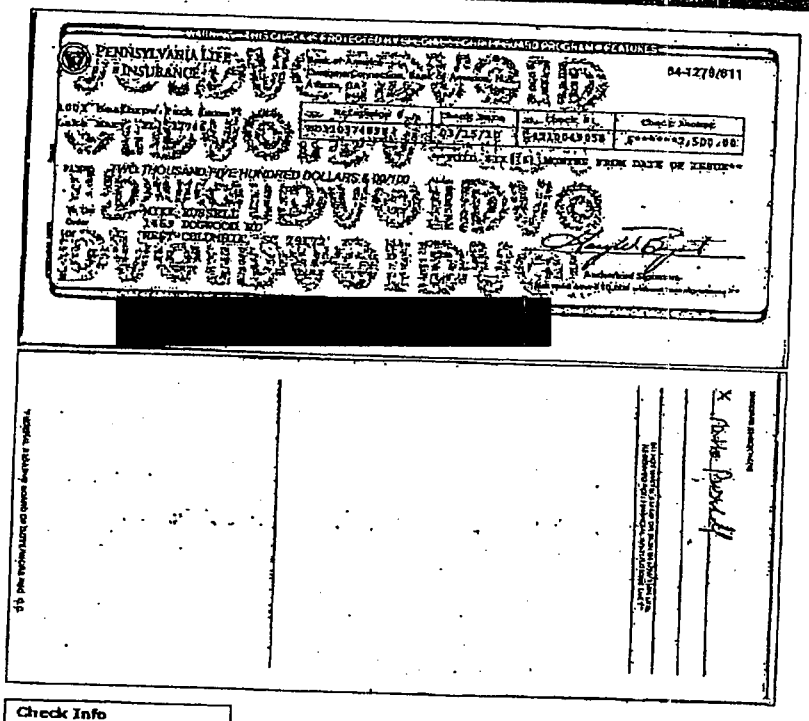
UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0003956781 MAR 01 2010
MAILED FROM ZIP CODE 28204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

Bank of America Higher Standards

Bank of America Direct®



Check Info	
Account:	[redacted]
Amount:	2,500.00
Check #:	4210049058
Posted Date:	03/24/2010

Bank of America, N.A. Member FDIC.
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PLIC 0065

POLICY SCHEDULE

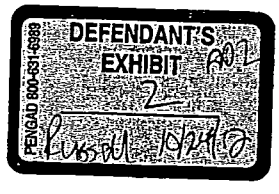
INSURED MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC
29172

POLICY NUMBER	[redacted]9360
POLICY DATE	11-19-99
FIRST RENEWAL DATE	12-19-99
ANNUAL PREMIUM	$1,501.97
MODE	MONTHLY PAC
MODE PREMIUM	$135.18

INITIAL ACCIDENT COVERAGE -- PRIMARY INSURED		EFFECTIVE DAT
MONTHLY TOTAL DISABILITY BENEFIT	$2,000.00*	11-19-99
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
MONTHLY TOTAL DISABILITY BENEFIT	$500.00*	07-19-02
MAXIMUM BENEFIT PERIOD	LIFETIME	
ELIMINATION PERIOD	7 DAYS	
ACCIDENTAL DEATH BENEFIT	$25,000.00	11-19-99
ACCIDENTAL DEATH BENEFIT	$75,000.00	07-19-02
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$1,000.00	11-19-99
MAXIMUM SURGICAL BENEFIT (SEE SCHEDULE IN RIDER)	$4,000.00	07-19-02
EMERGENCY TREATMENT BENEFIT	$25.00	07-19-02
RETURN OF PREMIUM RIDER	YES	11-19-99

* TOTAL DISABILITY BENEFITS MAY END FOR TOTAL DISABILITY STARTING AFTER AGE 65 (SEE TOTAL DISABILITY RIDER)

1900



Russell 0145

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

APPLICATION FOR INSURANCE

JUL 11 2002

POLICYHOLDER

DATE (MMDDYYYY): 06 27 2002

MAIL PREMIUM NOTICES: BUSINESS ✓ RESIDENCE ✓

POLICY NO. [redacted] 9360 INCREASE NEW ✓ CURRENT

INSURED NAME

LAST: Russell FIRST: Mike MI SUFFIX SOCIAL SECURITY NUMBER [redacted]

ADDRESS (Street/Rural Route) ADDRESS (Line 2)

CITY STATE: SC ZIP CODE: 29172 COUNTY: Lexington

AREA CODE/ TELEPHONE BEST TIME/ DAY TO CALL: Eve AGE: 29 BIRTHDATE (MMDDYYYY) [redacted] STATE OF BIRTH: IL SEX: M

HEIGHT (Ft. In.): 5 09 WEIGHT: 160 WEIGHT CHANGE LAST 12 MONTHS: NONE ✓ GAIN LOSS NUMBER OF LBS REASON

OCCUPATION: Siding CLASS: 2A Average Monthly Salaried Earnings (Gross)

Average Monthly Self-Employed Earnings After Expenses: 7500 EXACT DUTIES: Res. Home - Siding

EMPLOYER: Self AREA CODE/ TELEPHONE HIRE DATE: 1995

EMPLOYER ADDRESS (Street/ Rural Route): Same CITY STATE ZIP CODE

BENEFICIARY NAME: Susanne Russell RELATIONSHIP: wife

SPOUSE TO BE INSURED

LAST SUFFIX FIRST MI SOCIAL SECURITY NUMBER

AGE BIRTHDATE (MMDDYYYY) STATE OF BIRTH SEX Height (Ft. In.) WEIGHT Weight Change Last 12 Months: NONE GAIN LOSS Number of Lbs REASON

OCCUPATION CLASS Average Monthly Salaried Earnings (Gross) Average Monthly Self-Employed Earnings After Expenses EXACT DUTIES

EMPLOYER AREA CODE/ TELEPHONE HIRE DATE

EMPLOYER ADDRESS CITY STATE ZIP CODE

BENEFICIARY NAME RELATIONSHIP

CHILDREN TO BE INSURED UNDER THIS POLICY

LAST NAME FIRST NAME MI SEX AGE BIRTHDATE (MMDDYYYY)

JUL 11 2002

BUSINESS DEPT.

Please check one of the following: APP ORIGINAL 1900 ✓

I HEREBY APPLY FOR THE FOLLOWING COVERAGE FOR THE FAMILY MEMBERS NAMED ABOVE:

Form Series: Monthly ADB Riders - Not Available To Children

	PRIMARY INSURED MONTHLY AMT.	PRIMARY INSURED BENEFIT PERIOD	SPOUSE MONTHLY AMT	SPOUSE BENEFIT PERIOD
ACCIDENTAL DEATH BENEFIT (1933)	$	YEARS	$	YEARS
MOTOR VEHICLE ADB (1934)	$	YEARS	$	YEARS
COMMON CARRIER ADB (1935)	$	YEARS	$	YEARS
PREMIUM	$	$		

PAYMENT MODE:
ANNUAL
SEMIANNUAL
PAC ✓
PRD

ADB MODE PREMIUM $

OFFICE CODE AGENT NAME % OFFICE CODE SUBAGENT CODE NAME % AMOUNT PAID

044425 173416 RGT 8290

P-A-1900 SC Rev. II 4.95

Russell 0146

FORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 ✓ 1941 Benefit Elimination Insured L 07 183.50 Spouse	500 per month	per month	
OFF-JOB DISABILITY ACCIDENT* (1945) Benefit Elimination Insured Spouse	per month	per month	
HOSPITAL ACCIDENT 1902 1942	per day	per day	per day
SURGICAL ACCIDENT 1904 ✓ 1944 50.3	4000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946) 31.5	50 max	max	
ACCIDENT CONVALESCENT (1947) Multiple of Hospital Days:	per day	per day	per day
ACCIDENT INTENSIVE CARE (1948)	per day	per day	per day
PERSONAL CARE BENEFITS* 1949 ✓	per day	per day	
ACCIDENTAL DEATH 1903 ✓ 1943 71.25	75000 lump sum	lump sum	lump sum
DISABILITY SICKNESS* (1911) Benefit Elimination Insured Spouse	per month	per month	
HOSPITAL SICKNESS (1912)	per day	per day	per day
SURGICAL SICKNESS (1914)	max	max	max
SICKNESS CONVALESCENT (1957) Multiple of Hospital Days:	per day	per day	per day
SICKNESS INTENSIVE CARE (1964)	per day	per day	per day
OTHER RIDER:			
OTHER RIDER:			

ACCIDENT/SICKNESS PREMIUM (excl. Monthly ADB premium from front)	345.05 $ 27380	$	$
INFLATION PROTECTION YES	(Does NOT apply to Monthly ADB Riders included in the policy)		
A/S PREMIUM WITH INFLATION	$	$	$
PREMIUM INCL. MONTHLY ADB FROM FRONT	$	$	
INCREMENTAL COST	$ 27380		
SUBTOTAL	$	$	$
WAIVER OF PREMIUM YES	$ 458.92	113.17	TOTAL MODE PREMIUM: 41.30
(Waiver of Premium will apply to any Monthly ADB Riders included)			
TOTAL PREMIUM - ALL COVERED INSUREDS	$ 36415 (INC NOT 90.35)	$ 3	
Includes Inflation, Waiver and any Monthly ADB Premium		(Includes ADB premium from front)	

P-A-1900 SC Rev. II 4.95 *Disability Income, Emergency Treatment and Personal Care benefits NOT available to children 2

Russell 0147

COMPLETE FOR ALL COVERAGES - GIVE DETAILS BELOW

	YES	NO
1. Does any Family Member to be insured have any hospital, disability, emergency treatment or accident and sickness insurance currently in force, or do you or your spouse have an application for insurance pending?	✓	
2. Does any Family Member to be insured have, or within the past five (5) years has any Family Member had, other coverage with Pennsylvania Life Insurance Company?	✓	
3. Do you intend to replace any existing insurance with the insurance now applied for?		✓
4. Are you or your spouse currently disabled?		✓
5. Has any application for life or disability income insurance been declined, postponed, modified, cancelled or renewal refused within the past five (5) years?		✓

COMPLETE IF APPLYING FOR PERSONAL CARE BENEFITS - GIVE DETAILS BELOW

6. During the past three years, have you or any family member applying for this benefit been confined to a wheelchair or to bed or been required to use a walker for more than 30 cumulative days as the result of an accident?		✓

COMPLETE IF APPLYING FOR ACCIDENT RIDERS ONLY - GIVE DETAILS BELOW

7. Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?		✓
8. Has any person named on this application been hospitalized in the last 6 months?		✓
9. Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for injury?		✓
10. To the best of your knowledge and belief, do you or any of the Family Members applying for coverage have, had, or been treated for any of the following within the past five (5) years:		
a. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?		✓
b. Disorder or disease of the muscles, bones, back or spine?		✓
11. Other than already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
a. Received medical attention for any injury, or been advised to have a surgical operation which has not been performed?		✓
b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?		✓

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 11:

Ques. No.	Name of Person	Company	Type (or Policy No.)	Doctor's Name and Address. Details of medical condition. If showing existing insurance, give benefit amounts, benefit and elimination periods.
1-2	Russell	Penn Life	# [redacted]9360	

COMPLETE IF APPLYING FOR ACCIDENT AND SICKNESS RIDERS — GIVE DETAILS BELOW

		YES	NO
12.	Have you or your spouse been totally or partially disabled as the result of accidents for more than 10 consecutive days or for more than 30 cumulative days within the last two years?		✓
13.	Has any person named on this application been hospitalized in the last 6 months?		✓
14.	Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for sickness or injury?		✓
15.	Have you or your spouse lost 10 or more days from work during the last 12 months for sickness?		✓
16.	Has any Family Member to be covered ever been institutionalized in a medical or mental facility for any reason?		✓
17.	To the best of your knowledge and belief do you or any of the Family Members applying for coverage have, had or been treated for any of the following within the past five (5) years:		
	a. Any deformity or loss of limb; or any disorder of the eyes, ears or throat?		✓
	b. Diabetes, skin disease, hernia, or any glandular disorder?		✓
	c. Nervous or emotional disorder or any disease of the brain or nervous system?		✓
	d. Lung disorder or any disease of the respiratory system; or heart disease, murmur, abnormal blood pressure, stroke or any other disorder of the blood?		✓
	e. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?		✓
	f. Disorder or disease of the muscles, bones, back or spine; or disease or disorder of the kidneys or genito-urinary system?		✓
	g. Disorder or disease of the gastrointestinal system; or liver, pancreas or gall bladder disorder?		✓
	h. Cancer, tumor, cyst or growth of any type; or rectal disorder?		✓
18.	Other than as already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
	a. Received medical attention for any sickness or injury, or been advised to have a surgical operation which has not been performed?		✓
	b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?		✓

GIVE DETAILS OF ANY "YES" ANSWER TO ANY PART OF QUESTIONS 12 THROUGH 18:

Ques. No.	Name of Person	Dates of onset and recovery	Nature of each injury, illness or consultation	Describe treatment or surgery	Name and address of doctor and/or hospital

NOTE: If all coverage applied for on the primary insured is declined, we will substitute the spouse (if applying for coverage) as the policy's primary insured.

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

[signature] 173416
Signature of Licensed Agent — Agent #

Signature of Licensed Agent — Agent #

Application Signed in:
Columbia — SC — 6/22/02
City — State — Date

I hereby apply to Pennsylvania Life Insurance Company for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company.

[signature]
Signature of Applicant

Signature of Spouse (if insured)

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank.
The coverage you are applying for is not Workers' Compensation; a replacement for Workers' Compensation; nor an alternative to Workers' Compensation.

P-A-1900 SC Rev. II 4.95

Russell 0149

PENNSYLVANIA LIFE INSURANCE CO.

JULY 25 2002

MIKE RUSSELL

Dear MR. RUSSELL: Policy Number: [redacted]9360

We are pleased to advise you that the additional benefits for which you recently applied have been approved.

Your new policy schedule reflects the benefits currently in force. Please read the enclosed description of your benefits and attach the information to your policy.

If you have any questions regarding your new benefits or additional life, accident or health insurance needs, please contact your agent or call one of our customer service representatives toll-free at 1-800-275-7366.

Sincerely,

William E Wehner

William E. Wehner, President
PENNSYLVANIA LIFE INSURANCE COMPANY

CC: 173416 GILL, RANDOLPH
091476 SC00044425

600 Courtland Street - Suite 400, Orlando, Florida 32804
(800) 275-7366

ADWEL

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lumberton, Pennsylvania
Executive Office: 2610 Wycliff Road,
Raleigh, NC 27607
P.O. Box 10234, Raleigh, NC 27605
(919) 786-8900 - (800) 275-7366

APPLICATION FOR RETURN OF PREMIUM INSURANCE

DATE

MO.	DAY	YEAR
6	27	02

POLICY NO. (if applicable) [redacted]9360 Date of Birth: MO. DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: Mike Russell

ADDRESS: Street ✓ City State Zip Code

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☑ RETURN OF PREMIUM 1900/APP SERIES (PR-301) ☐ RETURN OF PREMIUM OTHER POLICY SERIES (PR-300)

Total Annual ROP Premium $ 113.87

Premium Mode PAC

Amount Paid With Application 20.50

COMPLETE FOR RETURN OF PREMIUM COVERAGE

1. Within the past two years have you or any covered family member submitted a claim on any accident or sickness policy with our Company? ☐ YES ☑ NO

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of Licensed Agent 173416 Agent Code

Signature of 2nd Agent Agent Code

Dated at Columbia City SC State

I hereby apply to Pennsylvania Life Insurance Company for coverage to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company and all delivery requirements are met.

✓ Signature of Primary Insured

JUL 1 [illegible]

All premium checks must be payable to the Company; do not make checks payable to the agent or leave payee blank.

OFFICE CODE	AGENT CODE	CC	NAME	SUBAGENT CODE	CC	NAME	AMT. PAID
044425	173416		RCIC				20.50

P-A-300 Ed. 3-97

Russell 0151

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) Injury causes Total Disability which starts within 30 days after the date of the accident and continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under the Regular and Personal Care of a Physician; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Policy Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care of a Physician continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one accident.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Policy was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if Injury results in you or your Covered Spouse being confined in a Hospital as a resident patient under the Regular and Personal Care of a Physician. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for Total Disability end.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods: (a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser

Secretary

William E. Wehner

President

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENTAL DEATH BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

If injury results in the death of a Covered Family Member within 90 days of the accident, we will pay the Accidental Death Benefit shown in the Policy Schedule to the designated Beneficiary.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for death which results from injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J Peter Keuser

Secretary

William E Wehner

President

PR-1903 SC

10.91

Russell 0154

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT SURGICAL INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is a resident patient in a Hospital; and
2. The Hospital stay is for a covered Injury; and
3. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Accident Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity, except that no amount is payable for dental treatment unless such treatment results from accidental bodily injury to natural teeth or gums. If a covered surgical procedure is performed on an Insured who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Accident Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one accident.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. An adopted child will be covered retroactively from the moment of birth when: (1) a decree of adoption by the Insured has been entered within 31 days after the date of birth; or (2) adoption proceedings have been instituted by the Insured within 31 days after the date of birth and the Insured has temporary custody. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for covered surgical procedures resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

An adopted child will also be covered when the adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J. Peter Keuser — Secretary

William E. Wehner — President

PR-1904 SC 10.91

Russell 0155

ACCIDENT SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc.

URINARY TRACT

Nephrectomy	$400.00
Nephroctomy, nephropexy, ureterotomy	$250.00
Cystoscopy for diagnosis only	$100.00
Operation for repair of urethra	$ 50.00

SPINE

Fracture of any vertebrae requiring removal of a portion thereof (coccyx and process excepted)	$500.00
Fracture of any vertebral process requiring removal	$250.00
Removal of nucleus pulposus or intervertebral disc	$250.00
Bone graft or fusion operation	$200.00
Fracture of sacrum or coccyx requiring open operation or removal of coccyx	$ 75.00

EXTREMITIES-UPPER

Amputation:	
At shoulder joint or resection of shoulder	$325.00
Of arm or forearm at or above wrist or resection of elbow or wrist	$200.00
Of entire finger or any part of hand	$ 50.00
Of part of finger (one or two phalanges)	$ 50.00
Fractures, Reduction:	
Of bones of arm or forearm	$150.00
Of any of the bones of wrist, hand or fingers	$ 50.00
Dislocation:	
Reduction of dislocation of shoulder or elbow joint	$ 50.00

EXTREMITIES-LOWER

Amputation:	
At hip joint	$500.00
Of thigh or leg at or above ankle – resection of knee or ankle joint	$250.00
Of any part of foot or complete toe	$ 50.00
Of any part of toe	$ 50.00
Fractures, Reduction:	
Of femur or pelvic bones, removal of semi-lunar cartilage	$150.00
Of bone or bones of leg	$125.00
Of any of the bones of tarsus or patella	$ 75.00
Of any other bones of foot	$ 50.00
Dislocations:	
Reduction of dislocation of hip or knee joint	$ 50.00

The amounts shown for fractures in Extremities-Upper and Lower are for simple fracture. For fractures requiring open reduction the maximum will be one and one-half times the amount for the corresponding simple fracture. For a fracture requiring an operation with bone grafting or metallic fixation at point of fracture, the maximum will be twice the amount for the corresponding simple fracture.

OSTEOMYELITIS

Osteomyelitis requiring:	
Cutting operation for removal of bone other than simple curettement of infected area, bones of skull, spine, pelvis, femur, leg, humerus, forearm	$125.00
Bones of tarsus, carpus, hand or foot	$ 50.00
Simple incision including curettement of bones for bone infection	$ 50.00

MISCELLANEOUS

Suturing surface wound	$ 25.00
Blood transfusion--plasma	$ 50.00
Incision for drainage of superficial infections	$ 25.00

HEAD

Cutting into cranial cavity	$325.00
Reduction of fracture of maxilla (upper or lower)	$ 50.00
requiring wiring of teeth or bone	$125.00

EYES

Operation for detached retina	$325.00
Removal or evisceration of both eyes	$325.00
Removal or evisceration of one eye	$150.00
Removal or foreign body from eye or eyelid	$ 25.00

NOSE

Reduction of fracture of nasal bones	$ 50.00

NECK

Tracheotomy	$ 75.00

CHEST

Complete pneumonectomy, lobectomy	$325.00
Bronchoscopy	$100.00
Aspiration--artificial pneumothorax	$ 50.00
Reduction of fracture of one or more ribs	$ 50.00

ABDOMEN

Gastrectomy, entero-enterostomy, splenectomy	$250.00
Intestinal resection	$250.00
Colostomy, closure of perforations	$250.00
Laparotomy	$250.00
Repair of hernia, single	$150.00
double	$250.00
Gastroscopy	$ 75.00
Paracentesis of abdomen	$ 50.00

Russell 0156

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 600 Courtland Street
Suite 400
Orlando, FL 32804
(800) 275-7366

ACCIDENT EMERGENCY TREATMENT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

EMERGENCY TREATMENT BENEFIT

If Injury results in a Covered Family Member receiving Emergency Treatment in a Hospital Emergency Room, we will pay two times the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will only pay this benefit once for a Covered Family Member for any one Injury.

If Injury results in a Covered Family Member receiving Emergency Treatment in an Acute Care Facility, we will pay the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will pay this benefit once for a Covered Family Member for any one Injury. Treatment in an Acute Care Facility is subject to a maximum of two emergency visits per calendar year for each Covered Family Member.

X-RAY BENEFIT: If the Emergency Treatment for a covered Injury includes X-rays required by a Physician, we will pay an X-Ray Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will only pay this benefit once for a Covered Family Member for any one Injury.

CAST, SPLINT OR CRUTCHES BENEFIT: If the Covered Family Member receiving Emergency Treatment requires a cast, splint or crutches as the result of a covered Injury, we will pay a Cast, Splint or Crutches Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will pay this benefit only once, for only one of these requirements, for any one Injury. Such cast, splint or crutches must be recommended by a Physician and thereafter applied in the Hospital Emergency Room or Acute Care Facility.

AMBULANCE BENEFIT: If as a result of a covered Injury, a Covered Family Member requires transportation in an ambulance to or from a Hospital, we will pay an Ambulance Benefit equal to two times the Emergency Treatment Benefit amount shown in the Policy Schedule, for up to two trips for any one Injury.

DEFINITIONS

ACUTE CARE FACILITY means a facility providing care to patients who are not medically stable and who require frequent monitoring by health care professionals. This does not include the office of a private Physician.

ANY ONE INJURY when used in this Rider means losses incurred or medical treatment required arising out of the same accident.

CAST/SPLINT means a temporary device used to prevent motion of a joint or of the end of a fractured or broken bone. A cast/splint does not mean a brace.

CRUTCH means a support used under the armpits as an aid in walking. A crutch does not mean a cane, walker, wheelchair or other mobility device.

EMERGENCY TREATMENT means medical care for a covered Injury provided by a Physician within 72 hours of the time of the accident.

HOSPITAL EMERGENCY ROOM means a duly accredited facility set aside as such in a Hospital.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Rider effective date, only fraudulent misstatements made by you in the application for this Rider shall be used to void the Rider or to deny a claim for loss incurred commencing after the expiration of such two-year period.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement.If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to injury sustained after the date of reinstatement, subject to any provisions endorsed on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of PENNSYLVANIA LIFE INSURANCE COMPANY.

J Peter Lusser

Secretary

William E. Wehner

President

PR-1946 Ed. 11.96

Russell 0158

Lexington Family Practice White Knoll

5535 Platt Springs Road
Lexington, South Carolina 29073

PATIENT: RUSSELL, MIKE C	VISIT DATE: 01/04/2008
PATIENT #: [redacted] XXX-X1-7773	D: 01/04/2008 1:24 PM
PHYSICIAN: TERRY L NAGEL, DO	T: 01/04/2008 8:34 PM / cmh
	DATE OF BIRTH: [redacted]

S: The patient is a 35-year-old white male who presents today complaining of left rib pain. He states New Year's Eve, he got drunk, was messing around at home and tripped and fell. He landed with his left ribs on top of a chair. He complains of pain in that area. It hurts to move and twist. Two days later, he sought care at the Emergency Department because of the pain in the left ribs. He had a workup there to include x-rays of his left ribs which were negative. He also had a chest x-ray, which was unremarkable. Urinalysis was unremarkable. He was sent home with Percocet (#12). He is on his last pill. He states he is still having pain and would like to be evaluated. He denies any radicular pain or paresthesias. Denies any cough, fevers, chills, nausea, or vomiting. He denies any hematuria. PMH: Otherwise unremarkable. SH: Positive for smoking and alcohol use. FH: Mother died from lung cancer, father died from motor vehicle accident. PSH: Inguinal herniorrhaphy repair. ALLERGIES: None known. ROS: As above, otherwise negative. Patient counseled on smoking cessation and is interested and ready to quit.

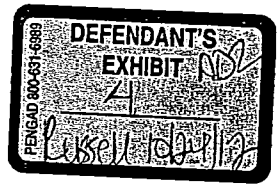
O: VITAL SIGNS: Weigh 185, temperature 97.5, pulse 88, respiratory rate 16, blood pressure 128/86. GENERAL: Alert x3, no acute distress. Nontoxic appearing. HEENT: Normocephalic, atraumatic. Pupils equal, round, reactive to light. Extraocular muscles intact. TMs clear, nares clear. Throat clear. NECK: Supple, no JVD, no thyromegaly. Trachea midline. LUNGS: Clear. No wheezes, rhonchi, rales or rubs. HEART: Regular rate and rhythm. ABDOMEN: Soft, nontender, no hepatosplenomegaly, rebound, or guarding. EXTREMITIES: No cyanosis, clubbing or edema. MUSCULOSKELETAL: Left ribs, slight bruise, little superficial abrasion from where he hit the chair, little bit of pain with palpation over the rib area but no palpable step off or deformity could be appreciated. CLINICAL COURSE: Emergency Department records obtained, reviewed and will be made part of the chart.

A
1. Rib contusion.
2. Abrasion, left ribs.
3. Nicotine abuse/smoking cessation.

P: Rx Percocet 5/325 mg p.o. every 4-6 hours p.r.n. pain, drowsiness precautions given (#30), Motrin 800 mg p.o. every 8 hours, GI precautions given with this, Chantix (starting month pack, continuing month pack) regarding nicotine abuse. Side effects, risks, benefits, etc., discussed with patient. Recheck in 1-2 weeks if not better, sooner if worse or if any problems, questions or concerns should arise otherwise.

TERRY L NAGEL, DO

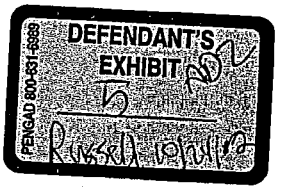
cc:



TRANSCRIPTION OF
MAGISTRATE'S COURT HEARING

Judge: This is uh, May the 15th, 2009. Ticket D 365378 charging Michael Russell was driving under the influence. D 365377 charging with expired motorcycle license, Trooper Harmon representing the State, Mr. Harpootlian representing the defense in this case and they have a motion that they want to make before the trial starts.

Harpootlian: If it please the court, Your Honor, in order to save time, um, we are ready to proceed today in the defense of this case, and uh, if factual background, there was a wreck involved. Blood was drawn, pursuant to a request by the Trooper and it was sent to SLED to be analyzed and we are ready to go forward today, my understanding is that the, the uh, the person who drew the blood nor the SLED chemist who analyzed the blood is here, uh, without the blood alcohol, there is a wrap in uh, evidence of intoxication, I mean blood alcohol is needed for the prosecution. We move to dismiss in that we're here ready to go today and the State is not with the witnesses they need to prove the blood alcohol in the case. We asked that it be dismissed. And Your Honor, I would state that I think the case law is clear, uh, that the at least the person who drew it and would have to be able to testify they drew it with a non-alcohol prep and the chemist, definitely the chemist who did the analysis would have to be present, uh, you can't make that through the document.



Trooper: Your Honor, if I may.

Judge: Yes sir.

Trooper: At, at this point, as far as his, his statement that the person who drew the blood has to be present, the case law doesn't show that the person that drew the blood has to be present. What the case law shows and states and what the law states is that someone has to be able to testify to the fact that it was done with a non-alcohol base prep, that it was done, in front of me, that it was sealed in front of me, and uh, I can testify to that because I was the one standing there which requested it and had the, the person who drew the blood used a non-alcohol base prep while I watched the entire thing and had it sealed in front of me. So ...

Harpootlian: I would disagree with ... I don't think we need to reach that though ... the chemist is here to testify as to the test and what the results were. Uh, we believe that the test did not come in under several different cases.

Judge: Y'all, y'all wanted the chemist here, is that ... ?

Harpootlian: Yes sir. Well, I mean, we're not going to stipulate to the results. Uh, without the chemist here, the results would not come in. Without the point ... whatever the blood alcohol reading was ... uh, I would submit that we are entitled to a dismissal on this case.

Judge: You are correct in what you are talking about also but, and let's say we want to stipulate that they can request, the statute says they can request that the, you know, chemist be present and uh, uh, so like simple possession of marijuana, there is a specific section in there that talks about as long as it's on the documentation from SLED or from the Sheriff's Department then you don't have to have it here but in, in the DUI statute, it talks about the chemist, you know, to be present and in any of these problems we have on this event is that's what they're requesting unless they stipulate to it.

Harpootlian: Well, Your Honor, then what I'd like to do then, so that the record is clear, um, is, I would waive our hearing trial, have the matter before you and um, without the blood alcohol, ask you to dismiss the case. So we can get this over with and move onto whatever the next case is.

Female: ... it is going to be your responsibility ...

Male?: ... that's fine ...

Female: ... go to ...

Harpootlian: So we move for a dismissal, Your Honor.

Judge: Okay. Anything else, sir?

Trooper: No, sir.

Judge: Granted.

Harpootlian: Thank you, Your Honor.

Judge: Alrighty. Um, y'all have a nice day.

Harpootlian: Thank you, Your Honor.

Judge: Uh, hmmm.

[BACKGROUND NOISE]

Judge: Was that, how about, was a motorcycle accident involved in that also?

Harpootlian: What was ...

Judge: ... expired motorcycle license ... in ...

[BACKGROUND NOISE]

Harpootlian: My, he had an expired motorcycle license, it's that 237-50, we don't have a defense to that. He'll pay that.

Harpootlian: ... it was expiring or had expired ... [INAUDIBLE]

Judge: You got that with you today sir?

Defendant: Uh, well, uh, I have a check and a debit card but I don't have the money with me, no ...

Judge: Um ...

Defendant: I can sign ... [INAUDIBLE]

Judge: Well, I'll make an exception, if it's good ... if it ain't any good ...

[SEVERAL SPEAKING BRIEFLY - INAUDIBLE]

[END OF TAPE]

~#4850-4770-3559 v.1 ~

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF LEXINGTON)
SC
Michael Russell and Susanne Russell FILED) CIVIL ACTION COVERSHEET
Plaintiff(s))
2008 AUG 19 P 3:14 2008-CP - 32- _____
vs.)
Connie Collins BETTY A. CARRIGG CLERK OF COURT 2008CP3203411
Defendant(s) SC

(Please Print)
Submitted By: Richard A. Harpootlian SC Bar #: 2725
Address: 1410 Laurel Street Telephone #: (803) 252-4848
Columbia, SC 29201 Fax #: (803) 252-4810
Other:
E-mail: rah@harpootlianlaw.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (*Check all that apply*)

**If Action is Judgment/Settlement do not complete*

☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (*Check One Box Below*)

Contracts
- ☐ Constructions (100)
- ☐ Debt Collection (110)
- ☐ Employment (120)
- ☐ General (130)
- ☐ Breach of Contract (140)
- ☐ Other (199)

Torts - Professional Malpractice
- ☐ Dental Malpractice (200)
- ☐ Legal Malpractice (210)
- ☐ Medical Malpractice (220)
- ☐ Notice/ File Med Mal (230)
- ☐ Other (299)

Torts – Personal Injury
- ☐ Assault/Slander/Libel (300)
- ☐ Conversion (310)
- ☒ Motor Vehicle Accident (320)
- ☐ Premises Liability (330)
- ☐ Products Liability (340)
- ☐ Personal Injury (350)
- ☐ Wrongful Death (360)
- ☐ Other (399)

Real Property
- ☐ Claim & Delivery (400)
- ☐ Condemnation (410)
- ☐ Foreclosure (420)
- ☐ Mechanic's Lien (430)
- ☐ Partition (440)
- ☐ Possession (450)
- ☐ Building Code Violation (460)
- ☐ Other (499)

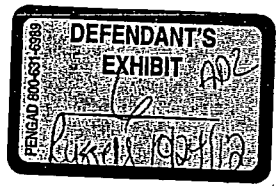
Inmate Petitions
- ☐ PCR (500)
- ☐ Mandamus (520)
- ☐ Habeas Corpus (530)
- ☐ Other (599)

Judgments/Settlements
- ☐ Death Settlement (700)
- ☐ Foreign Judgment (710)
- ☐ Magistrate's Judgment (720)
- ☐ Minor Settlement (730)
- ☐ Transcript Judgment (740)
- ☐ Lis Pendens (750)
- ☐ Other (799)

Administrative Law/Relief
- ☐ Reinstate Driver's License (800)
- ☐ Judicial Review (810)
- ☐ Relief (820)
- ☐ Permanent Injunction (830)
- ☐ Forfeiture-Petition (840)
- ☐ Forfeiture—Consent Order (850)
- ☐ Other (899)

Appeals
- ☐ Arbitration (900)
- ☐ Magistrate-Civil (910)
- ☐ Magistrate-Criminal (920)
- ☐ Municipal (930)
- ☐ Probate Court (940)
- ☐ SCDOT (950)
- ☐ Worker's Comp (960)
- ☐ Zoning Board (970)
- ☐ Administrative Law Judge (980)
- ☐ Public Service Commission (990)
- ☐ Employment Security Comm (991)
- ☐ Other (999)

Special/Complex /Other
- ☐ Environmental (600)
- ☐ Automobile Arb. (610)
- ☐ Medical (620)
- ☐ Other (699)
- ☐ Pharmaceuticals (630)
- ☐ Unfair Trade Practices (640)
- ☐ Out-of State Depositions (650)
- ☐ Sexual Predator (510)



Submitting Party Signature: _____ **Date:** August 18, 2008

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON)	
	FILED
	2008 AUG 19 P 3:14
Michael Russell and Susanne)	Civil Action No.: 2008-CP-32-
Russell,)	BETTIA CARRIGG
)	CLERK OF COURT
)	LEXINGTON SC
Plaintiffs,)	**SUMMONS**
)	(Jury Trial Requested)
vs.)	
)	2008CP3203411
Connie Collins,)	
)	
Defendant.)	
)	

TO: THE ABOVE NAMED DEFENDANT:

YOU ARE HEREBY SUMMONED and required to answer the Complaint herein, a copy of which is herewith served upon you, and to serve a copy of your answer to said Complaint upon the subscriber, Richard A. Harpootlian, P.A. located at 1410 Laurel Street, Columbia, South Carolina 29201, within THIRTY (30) DAYS pursuant to S.C.R.C.P. 12 after service hereof, exclusive of the day of such service, and if you fail to answer the Complaint within the time aforesaid, Judgment by default will be rendered against you for the relief demanded in the Complaint.

Richard A. Harpootlian
Graham L. Newman
RICHARD A. HARPOOTLIAN, P.A.
1410 Laurel Street
Post Office Box 1090
Columbia, South Carolina 29202
Telephone: (803) 252-4848
Facsimile: (803) 252-4810

Columbia, South Carolina
August 18, 2008

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON)	
	2008 AUG 19 P 3:14
MICHAEL RUSSELL AND)	Civil Action No. 2008-CP-32-
SUSANNE RUSSELL,)	
)	BETTY A. CARRIGG CLERK OF COURT LEXINGTON SC
Plaintiffs,)	
vs.)	COMPLAINT
)	(Jury Trial Requested)
CONNIE COLLINS,)	
)	
Defendant.)	2008CP3203411

FILED

The Plaintiffs, complaining of the Defendant herein, would respectfully show unto this Court as follows:

PARTIES, JURISDICTION, AND VENUE

1. Plaintiffs, Michael and Susanne Russell, are citizens of the State of South Carolina and residents of the County of Lexington.

2. Defendant Connie Collins is upon information and belief, a resident of Lexington County, South Carolina. The Defendant was a resident of the County of Lexington at the time of the incident complained of herein.

3. This Court has jurisdiction over the subject matter of this action pursuant to Article V, § 11 of the South Carolina Constitution. Venue is proper in this County pursuant to S.C. Code Ann. § 15-7-30(C)(1) (2006).

FACTUAL BACKGROUND

4. On June 18, 2008 around 9:24 p.m., Plaintiff Michael Russell was traveling eastbound on Interstate 26, in Lexington County. He was the lone occupant of his 1998 Harley Davidson Motorcycle.

5. At this same time, Defendant Collins was driving her vehicle in the same direction as Mr. Russell, several car lengths ahead of him on the highway.

6. Defendant Collins and Mr. Russell exited Interstate 26 at exit number 115. At that point, Defendant Collins quickly and suddenly applied the brakes of her car, blocking the flow of traffic and leaving Mr. Russell without enough room to properly stop his motorcycle. Russell's motorcycle then impacted the rear of Collins' vehicle with great force.

7. The impact of the wreck threw Mr. Russell from his motorcycle and he suffered extensive physical injuries. Mr. Russell's injuries required surgery and caused him to incur significant costs for medical care and services. He is expected to undergo physical therapy for his leg throughout the foreseeable future.

8. As a result of the incident, Mr. Russell has missed numerous days of work, resulting in lost wages.

AS A FIRST CAUSE OF ACTION AGAINST DEFENDANT
(Negligence, Negligence *per se*, Gross Negligence, Willful, Wanton, Reckless Misconduct)

9. Paragraphs one (1) through eight (8) are incorporated by reference as if repeated verbatim herein.

10. Defendant Collins owed a duty to Mr. Russell to abide by all traffic laws of South Carolina while traveling upon the highways of this state. Defendant Collins also owed a duty to Mr. Russell that she would exercise due care in the operation of her vehicle.

11. Defendant Collins, during the operation of her motor vehicle, violated these several duties owed to Michael Russell and was negligent in the following particulars:

i) by failing to keep a proper lookout;

ii) by traveling beneath the minimum speed limit in violation of S.C. Code Ann. § 56-5-1560;

iii) by stopping her vehicle within a roadway and lane of travel without just cause in violation of S.C. Code Ann. § 56-5-2510; and

iv) by failing to use due care in the operation of a motor vehicle.

12. Whereas Defendant Collins' acts or omissions violated several safety statutes (noted in paragraph 12), her acts or omissions constitute negligence *per se*.

13. Defendant Collins' acts or omissions were grossly negligent and were committed willfully, wantonly and with reckless disregard for the safety of others, including Michael Russell.

14. As a direct and proximate result of Defendant Collins' breaches of her duties outlined above, Mr. Russell suffered significant injuries including (but not necessarily limited to) permanent disability, scarring, deformity, significant medical bills, pain and suffering, mental and emotional distress, loss of enjoyment of life, and loss of wages.

15. Mr. Russell is entitled to judgment against the Defendant in an amount sufficient to compensate him for the damages he suffered. In addition, the Plaintiff is entitled to an award of punitive damages in an amount to be determined by a jury in an amount sufficient to impress upon Defendant the seriousness of her misconduct and to deter similar misconduct in the future.

AS A SECOND CAUSE OF ACTION BY PLAINTIFF SUSANNE RUSSELL AGAINST DEFENDANT
(Loss of Consortium)

16. Paragraphs one (1) through fifteen (15) above are incorporated as if repeated herein verbatim.

17. As a direct and proximate result of the Defendant's negligence, gross negligence, willful, wanton, and reckless misconduct, more thoroughly described above, Plaintiff Susanne Russell has suffered loss of consortium with her husband, Michael.

18. As a result of the Defendant's conduct, and as a proximate result thereof, Susanne has suffered extreme emotional distress and anguish and has been forced to endure substantial losses of the marital rights to company, society, cooperation, affection, assistance, fellowship, aid and sexual relations with her spouse. She has been deprived of the peaceful enjoyment of her marriage and she has had to perform substantially more work duties as a result of the devastating injuries to her husband.

WHEREFORE, Plaintiffs pray that judgment be entered against the Defendant. Plaintiffs pray for an award of damages sufficient to compensate them for the damages they suffered as a result of Defendant Collins negligence. In addition, Plaintiffs pray for an award of punitive damages sufficient to impress upon the Defendant the seriousness of her conduct, and to deter such similar conduct in the future. Finally, Plaintiffs pray for such other relief as the Court deems just and proper.

Richard A. Harpootlian, Esquire
Graham L. Newman, Esquire
RICHARD A. HARPOOTLIAN, P.A.
1410 Laurel Street
Post Office Box 1090

Columbia, SC 29202
Telephone: (803) 252-4848
Facsimile: (803) 252-4810

ATTORNEYS FOR PLAINTIFFS

Columbia, South Carolina
August 18, 2008

AUG 2 8

Richard A. Harpootlian, P.A.

ATTORNEYS AT LAW
P.O. BOX 1090
1410 LAUREL STREET
COLUMBIA, SOUTH CAROLINA 29202

RICHARD A. HARPOOTLIAN
rah@harpootlianlaw.com

TELEPHONE (803) 252-4848
FACSIMILE (803) 252-4810

FILED
2008 AUG 19 P 3:14
BETH A. CARRIGG
CLERK OF COURT
LEXINGTON SC

August 18, 2008

2008CP3203411

The Honorable Beth Carrigg
Lexington County Clerk of Court
205 East Main Street
Lexington, SC 29072

In re: Michael Russell and Susanne Russell v. Connie Collins

Dear Ms. Carrigg:

Enclosed please find for filing the originals and five (5) copies of each of the following documents:

1) Civil Action Coversheet;
2) Summons; and
3) Complaint.

I would appreciate you filing the enclosed and forwarding the clocked copies to me in the enclosed envelope. I have also enclosed the required filing fee.

Thank you for your assistance.

With warm personal regards, I am

Sincerely,

Richard A. Harpootlian

/sec
Enclosure(s)

STATE OF SOUTH CAROLINA COUNTY OF LEXINGTON	)	IN THE COURT OF COMMON PLEAS ELEVENTH JUDICIAL CIRCUIT
MICHAEL RUSSELL and SUSANNE RUSSELL, Plaintiffs, vs. CONNIE COLLINS, Defendant.	)	Civil Action No. 2008-CP-32-03411 **AFFIDAVIT OF SERVICE**

PERSONALLY APPEARED BEFORE ME, Steven A. Smith, does hereby state as follows:

I hereby certify that on August 25, 2008, at 6:54 p.m., I served by hand delivering to the person named below, at the address below, a copy of the following documents relating to the above-referenced matter.

Documents Served:

1) Civil Action Cover Sheet;
2) Summons;
3) Complaint;
4) Plaintiffs First Set of Interrogatories to Defendant; and
5) Plaintiffs First Set of Requests to Produce to Defendant.

Service Upon: Connie Collins
1124 Starcrest Road
West Columbia, SC 29172

FURTHER AFFIANT SAYETH NOT.

Steven A. Smith

SWORN TO BEFORE ME
This 27th day of August, 2008.

Sara E. Craft
Notary Public for South Carolina
My Commission Expires: July 17, 2012

Richard A. Harpootlian, P.A.

ATTORNEYS AT LAW
P.O. BOX 1090
1410 LAUREL STREET
COLUMBIA, SOUTH CAROLINA 29202

RICHARD A. HARPOOTLIAN
rah@harpootlianlaw.com

TELEPHONE (803) 252-4848
FACSIMILE (803) 252-4810

August 27, 2008

The Honorable Beth Carrigg
Lexington County Clerk of Court
205 East Main Street
Lexington, SC 29072

In re: Michael Russell and Susanne Russell v. Connie Collins
Civil Action No. 2008-CP-32-03411

Dear Ms. Carrigg:

Enclosed please find for filing the original and two (2) copies of the following documents:

1) Affidavit of Service

I would appreciate you filing the enclosed and forwarding the clocked copies to me in the enclosed envelope.

Thank you for your assistance.

With warm personal regards, I am

Sincerely,

Richard A. Harpootlian

Richard A. Harpootlian SEC

/sec
Enclosure(s)

SCANNED JM

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	ELEVENTH JUDICIAL CIRCUIT
COUNTY OF LEXINGTON	)	
MICHAEL RUSSELL and SUSANNE RUSSELL,	)	Civil Action No. 2008-CP-32-03411
Plaintiffs,	)	
vs.	)	**AFFIDAVIT OF SERVICE**
CONNIE COLLINS,	)	
Defendant.	)	

PERSONALLY APPEARED BEFORE ME, Steven A. Smith, does hereby state as follows:

I hereby certify that on August 25, 2008, at 6:54 p.m., I served by hand delivering to the person named below, at the address below, a copy of the following documents relating to the above-referenced matter.

Documents Served:

1) Civil Action Cover Sheet;
2) Summons;
3) Complaint;
4) Plaintiffs First Set of Interrogatories to Defendant; and
5) Plaintiffs First Set of Requests to Produce to Defendant.

Service Upon: Connie Collins
1124 Starcrest Road
West Columbia, SC 29172

FURTHER AFFIANT SAYETH NOT.

Steven A. Smith

SWORN TO BEFORE ME
This 27th day of August, 2008.
Sara E. Craft
Notary Public for South Carolina
My Commission Expires: July 17, 2012

FILED
2008 SEP -5 AM 7:42

Richard A. Harpootlian, P.A.

ATTORNEYS AT LAW
P.O. BOX 1090
1410 LAUREL STREET
COLUMBIA, SOUTH CAROLINA 29202

RICHARD A. HARPOOTLIAN
rah@harpootlianlaw.com

TELEPHONE (803) 252-4848
FACSIMILE (803) 252-4810

September 2, 2008

The Honorable Beth Carrigg
Lexington County Clerk of Court
205 East Main Street
Lexington, SC 29072

In re: Michael Russell and Susanne Russell v. Connie Collins
Civil Action No. 2008-CP-32-03411

Dear Ms. Carrigg:

Enclosed please find the original Affidavit of Service which should have been included with the filing letter dated August 27th.

With warm personal regards, I am

Sincerely,

Richard A. Harpootlian

/sec
Enclosure(s)

Filed
2008 SEP -5 AM 7:42

ORIGINAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Michael Russell and Susanne Russell,	)	Civil Action No. 2008-CP-32-03411
Plaintiffs,	)	
V's.	)	ANSWER AND COUNTERCLAIM
Connie Collins,	)	
Defendant	)	

EH SCANNED

Defendant, above named, answering the Plaintiffs' Complaint herein, and by way of a Counterclaim against Michael Russell would respectfully show unto the Court that:

1. The Defendant denies each and every allegation of the Plaintiffs' Complaint not hereinafter specifically admitted.

2. Paragraphs 1, 2 and 3 are admitted.

3. As to paragraphs 4, 5, and 6 the Defendant admits that on June 18, 2008 at approximately 9:24 p.m. while it was dark, Michael Russell was driving his 1998 Harley Davidson motorcycle in an easterly direction on Interstate I-26 in Lexington County while wearing sunglasses and no other head protection nor eye protection even though it was dark and while under the influence of alcohols, drugs or other intoxicating substances; the Defendant also admits that on June 18, 2008 at approximately 9:24 p.m. she was driving in an easterly direction on Interstate I-26 when she dropped her cell phone and that instead of reaching for her cell phone, exited the Interstate on the Exit 115 exit ramp and pulled completely off the left hand side of the exit ramp, into the grassy median and had retrieved her cell phone and was in the process of beginning to

put her vehicle into drive when Michael Russell exited Interstate I-26 at exit number 115 and ran the 1998 Harley Davidson motorcycle that he was driving into the right rear of the Defendant's vehicle; otherwise, paragraphs 4, 5 and 6 are denied and the Defendant specifically denies that she quickly or suddenly applied the brakes of her vehicle, blocked the flow of traffic and did not leave Michael Russell with enough room to properly stop his motorcycle or go around the Defendant; otherwise, those paragraphs are denied.

4. The Defendant does not have sufficient knowledge or information to form a belief as to exact nature or extent or the injuries and damages sustained by the Plaintiff and, therefore, denies paragraphs 7 and 8 in their entirety and demand strict proof thereof.

FOR A FIRST DEFENSE AS TO THE FIRST CAUSE OF ACTION

5. The Defendant denies each and every allegation of the Plaintiffs' first cause of action not hereinafter specifically admitted.

6. In response to paragraph 9, the Defendant realleges all of her responses contained in paragraphs 1 through 5 above as fully as if set forth verbatim herein.

7. Insofar as paragraphs is an allegation of law, the Defendant is not required to admit or deny that paragraph; however, subject to the above, the Defendant admits that both the Plaintiff and the Defendant owed each other a duty to abide by all traffic laws while traveling upon the highways of this state and the Plaintiff and the D3efendant owed each other a duty to exercise due care in the operation of their respective vehicle; otherwise, paragraph 10 is denied.

8. Paragraphs 11, 12 and 13 are denied.

9. The Defendant does not have sufficient knowledge or information to form a belief as to the exact or extent of the injuries or damages sustained by the Plaintiff and, therefore, denies paragraph 14 in its entirety and demands strict proof thereof. Otherwise, paragraph 14 is denied.

10. Paragraph 15 is denied.

FOR A FIRST DEFENSE AS TO THE SECOND CAUSE OF ACTION

11. The Defendant denies each and every allegation of the Plaintiffs' second cause of action not hereinafter specifically admitted.

12. In response to paragraph 16, the Defendant realleges all of her responses to paragraphs 1 through 11 above as fully as if set forth verbatim herein.

13. The Defendant does not have sufficient knowledge or information to form a belief as to the exact or extent of the injuries or damages sustained by either Plaintiff and, therefore, denies paragraphs 17 and 18 in their entirety and demands strict proof thereof. Otherwise, paragraphs 17 and 18 are denied.

FOR A SECOND DEFENSE

14. The Defendant would show, upon information and belief, that any injuries or damages sustained by the Plaintiffs were due to Plaintiff Michael Russell's own negligent, careless, reckless, and grossly negligent acts or omissions which combined and concurred with any negligence on the part of the Defendant, which is specifically denied, to produce such injuries or damages, if any, and without which such injuries or damages would not have occurred; such negligent, careless, reckless and grossly negligent acts or omissions on the part of the Plaintiff being more particularly set forth as follows:

a. in failing to maintain a proper lookout;

b. in failing to keep his/her vehicle under proper control;

c. in driving a vehicle at night while wearing sunglasses;

d. in failing to wear other head or eye protection other than sunglasses while driving a motorcycle at night;

e. in driving a motorcycles while under the influence of alcohol, drugs or other intoxicating substances,

f. in traveling at an excessive rate of speed in the circumstances then and there prevailing;

g. in failing to observe the road and traffic conditions then and there prevailing;

h. in following too closely;

i. in failing to take evasive action so as to avoid the collision;

j. in failing to apply his brakes, if any he had;

k. in failing to go around the Defendant

l. in failing to exercise that degree of care and caution that a reasonable and prudent person makes under the same and similar circumstances;

m. and such other particulars to be shown at trial;

all of which were the direct and proximate cause of any injuries or damages sustained by the Plaintiff and the Defendant pleads such contributory negligence, carelessness, recklessness, and gross negligence on the part of the Plaintiff as a complete defense to the Plaintiff's action.

FOR A THIRD DEFENSE

15. The Defendant would show, upon information and belief, that any injuries or damages sustained by the Plaintiff were due to his/her own negligent, careless, reckless and grossly negligent acts or omissions which combined and concurred with any negligence on the part of the Defendant, which is specifically denied, to produce such injuries or damages, if any, and without which such injuries or damages would not have

occurred; such negligent, careless, reckless and grossly negligent acts or omissions on the part of the Plaintiff being more particularly set forth as follows:

a. in failing to maintain a proper lookout;

b. in failing to keep his/her vehicle under proper control;

c. in driving a vehicle at night while wearing sunglasses;

d. in failing to wear other head or eye protection other than sunglasses while driving a motorcycle at night;

e. in driving a motorcycles while under the influence of alcohol, drugs or other intoxicating substances,

f. in traveling at an excessive rate of speed in the circumstances then and there prevailing;

g. in failing to observe the road and traffic conditions then and there prevailing;

h. following too closely;

i. in failing to take evasive action so as to avoid the collision;

j. in failing to apply his brakes, if any he had;

l. in failing to go around the Defendant

m. in failing to exercise that degree of care and caution that a reasonable and prudent person makes under the same and similar circumstances; and,

n. such other particulars to be shown at trial;

all of which were the direct and proximate cause of any injuries or damages sustained by the Plaintiff and the Defendant pleads such negligence, carelessness, recklessness and gross negligence on the part of the Plaintiff and would ask that this Court compare the negligence of the Plaintiff and the Defendant and if it is determined that the Plaintiff's negligence, carelessness, recklessness and gross negligence was greater than the negligence, carelessness, recklessness and gross negligence of the

Defendant, which is specifically denied, then the Plaintiff should be totally barred from recovery and if it is determined that the Plaintiff's negligence, carelessness, recklessness and gross negligence is equal to or less than the negligence of the Defendant, then the amount of recovery available to the Plaintiff should be reduced by the percentage of the Plaintiff's own negligence, carelessness, recklessness and gross negligence.

FOR A FOURTH DEFENSE

16. The Defendant would show, upon information and belief, that the Plaintiffs' claim for punitive damages violates the Fifth, Sixth, Seventh, Eighth and Fourteenth Amendments to the Constitution of the United States of America in that it violates the double jeopardy clause in that the Defendant could be subjected to multiple awards of punitive damages for the same set of facts, the self-incrimination clause is being violated because the Defendant can be compelled to give testimony against himself in a penalty situation such as punitive damages, the assessment of punitive damages by a burden of proof less than beyond a reasonable doubt is violative of the Sixth and Fourteenth Amendments in that punitive damages are a fine or penalty and are, therefore, quasi-criminal in nature, Plaintiffs' claim for punitive damages violates the Defendant's right to access to the courts as guaranteed by the Seventh and Fourteenth Amendments because the threat of an award of punitive damages chills the Defendant's exercise of that right, the Plaintiffs' claim for punitive damages violates the Eighth Amendment's guarantee that excessive fines shall not be imposed, and the Plaintiffs' claim for punitive damages violates both the due process and equal protection clauses of the Fourteenth Amendment in that the standard for awarding either punitive damages is unduly vague and, therefore, violates both procedural and substantive due process safeguards and, therefore, the Plaintiffs' claim for punitive damages should be dismissed.

FOR A FIFTH DEFENSE AND BY WAY OF COUNTERCLAIM AGAINT MICHALE RUSSELL

17. On June 18, 2008, at approximately 9:24 p.m., while it was dark, Michael Russell was driving his 1998 Harley Davidson motorcycle in an easterly direction on Interstate I-26 in Lexington County while wearing sunglasses and no other head protection nor eye protection even though it was dark and while under the influence of alcohol, drugs or other intoxicating substances.

18. On June 18, 2008 at approximately 9:24 p.m. the Defendant was driving her vehicle in an easterly direction on Interstate I-26 when she dropped her cell phone and instead of reaching for her cell phone, she exited the interstate on the exit 115 exit ramp and pulled completely off the left hand side of the exit ramp and completely into the grassy median and then received her cell phone and was in the process of putting her vehicle back into "drive" when Michael Russell exited Interstate I-26 at exit 115 and ran the Harley Davidson motorcycle he was driving into the right rear of the vehicle the Defendant was driving at a high rate of speed and while under the influence of alcohol, drugs or other intoxicating substances.

19. Michael Russell was negligent, careless, reckless, and grossly negligent in one or more of the following particulars:

a. in failing to maintain a proper lookout;

b. in failing to keep his/her vehicle under proper control;

c. in driving a vehicle at night while wearing sunglasses;

d. in failing to wear other head or eye protection other than sunglasses while driving a motorcycle at night;

e. in driving a motorcycles while under the influence of alcohol, drugs or other intoxicating substances,

f. in traveling at an excessive rate of speed in the circumstances then and there prevailing;

g. in failing to observe the road and traffic conditions then and there prevailing;

h. following too closely;

i. in failing to take evasive action so as to avoid the collision;

j. in failing to apply his brakes, if any he had;

k. in failing to go around the Defendant

l. in failing to exercise that degree of care and caution that a reasonable and prudent person makes under the same and similar circumstances; and,

m. such other particulars to be shown at trial;

all of which were the direct and proximate cause of the injuries and damages sustained by the Defendant and in violation of the statutory laws of the State of South Carolina.

20. That as a direct and proximate result of Michael Russell's negligent. careless, reckless, and grossly negligent acts or omissions, t he Defendant sustained serious and painful injuries to her left hip, left ankle, left arm, left shoulder, neck, back and head and the Defendant has and will in the future, incur medical and doctor expenses and has and in the future will suffer pain, suffering, discomfort, disability, mental and emotional distress, loss of enjoyment of life and loss of wages.

21. The Defendant is informed and believes that she is entitled to an award of actual and punitive damages against Michael Russell in an amount to be determined by a jury.

WHEREFORE, having fully answered and counterclaimed, the Defendant prays that the Plaintiffs' action against the Defendant be dismissed, with costs, and that the

Defendant be given judgment against Michael Russell in an amount of actual and punitive damages to be determined by a jury and for the costs of this action and for such other and further relief as this Court may deem just and proper.

BROWN & BREHMER

By: _____

Robert C. Brown
1720 Main Street, Suite 201
P. O. Box 7966
Columbia, SC 29202
(803) 771-6600/(803) 252-1620 fax

MCWHIRTER, BELLINGER & ASSOICATES, PA

Caroline Callison Tiffen
1807 Hampton Street
Columbia, SC 29201
(803) 252-5523/(803) 252-1248 fax

Columbia, South Carolina
September 24, 2008

ORIGINAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	ELEVENTH JUDICIAL CIRCUIT
Michael Russell and Susanne Russell,	)	Civil Action No. 2008-CP-32-03411
Plaintiffs,	)	
Vs.	)	CERTIFICATE OF SERVICE
Connie Collins,	)	
Defendant	)	

I, the undersigned employee of Brown & Brehmer, hereby certify that copies of the following documents have been served on the following individual(s) by depositing same in the United States Postal Service with the proper amount of first-class postage duly affixed this 25th day of September, 2008:

Pleadings: Answer and Counterclaim

Served On: **Richard A. Harpootlian, Esquire**
1410 Laurel Street
P. O. 1090
Columbia, SC 29202

Ginger C. Hughes

IKE

BROWN & BREHMER
Attorneys at Law
1720 MAIN STREET, SUITE 201
POST OFFICE BOX 7966
COLUMBIA, SOUTH CAROLINA 29202
TELEPHONE: (803) 771-6600
FACSIMILE: (803) 252-1620

ROBERT C. BROWN
KARL S. BREHMER
CHAD E. POTEAT
E. DALE LANG, JR.
J. AUSTIN HOOD
L. DARBY PLEXICO, III
ELY O. GROTE

OF COUNSEL
MICHAEL M. LUMPKIN

E-MAIL
LAWFIRM@BROWNANDBREHMER.COM
BOB.BROWN@BROWNANDBREHMER.COM
KARL.BREHMER@BROWNANDBREHMER.COM
CHAD.POTEAT@BROWNANDBREHMER.COM
DALE.LANG@BROWNANDBREHMER.COM
AUSTIN.HOOD@BROWNANDBREHMER.COM
LDP@BROWNANDBREHMER.COM
ELY.GROTE@BROWNANDBREHMER.COM

September 24, 2008

The Honorable Beth Carrigg
Clerk of Court, Lexington County
205 East Main Street
Lexington, SC 29072

RE: Russell v. Collins
Civil Action No. 2008-CP-32-3411

Dear Ms. Carrigg:

Enclosed please find the original and one (1) copy of the Defendant's Answer and Counterclaim pursuant to the above referenced matter. Please file the original and return the clocked in copy to this office in the enclosed, self addressed envelope.

By copy of this letter to Richard A. Harpootlian, I am serving him with a copy of the Answer and Counterclaim.

With warmest personal regards, I am

Yours very truly,

Robert C. Brown

RCB/gch
Enclosures

Cc: Richard A. Harpootlian

ORIGINAL

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF LEXINGTON	C/A NO.: 2008-CP-32-03411
Michael Russell and Susanne Russell, Plaintiffs, v. Connie Collins, Defendant.	NOTICE OF APPEARANCE

BERTHA C. HAGG
CLERK OF COURT
LEXINGTON, SC
2009 SEP 28 P 12:13
FILED
SCANNED
EH

TO: RICHARD A. HARPOOTLIAN, ESQUIRE AND GRAHAM L. NEWMAN, ESQUIRE, ATTORNEYS FOR PLAINTIFFS:

The undersigned hereby notifies and advises this court, the Plaintiff and his attorneys that he is appearing on behalf of The Travelers Home and Marine Insurance Company ("Travelers"), which has been served as a purported underinsured motorist carrier for the defendant in this matter. In making this appearance, Travelers specifically reserves and does not waive any rights pursuant to any policy of insurance, reserves all rights which it has under South Carolina Code Ann. § 38-77-160 (1976), as amended, and further requests that copies of all pleadings and discovery heretofore or hereafter exchanged between the parties be served upon the undersigned counsel at the address shown below. Said company's appearance in this matter is pursuant to a full reservation of rights under all terms of the subject policy, including the right to deny the availability of underinsured motorist coverage under said policy, and its appearance in this action does not constitute and is not intended as a waiver of any rights or defenses available to it. All correspondence as between the Court and the Defendants or between counsel for Defendant and Plaintiffs in this matter should be directed to the undersigned.

Kirby D. Shealy III

BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400
Post Office Box 8057
Columbia, South Carolina 29202
(803) 799-9091
Attorneys for The Travelers Home and Marine Insurance Company, a purported underinsured motorist carrier for the defendant

September 24th, 2009.

ORIGINAL

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF LEXINGTON	)	C/A NO.: 2008-CP-32-03411
	)	
Michael Russell and Susanne Russell,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**CERTIFICATE OF SERVICE**
	)	
Connie Collins,	)	
	)	
Defendant.	)	
	)	

I, Ida M. Thomas, Legal Assistant to Kirby D. Shealy III, an employee of Baker, Ravenel & Bender, L.L.P., hereby certify that I have, on this 24th day of Sept., 2009, I have served counsel below with **a Notice of Appearance** by mailing a copy of same via United States Mail, postage pre-paid the return address clearly indicated on the envelope to counsel at the following address:

Richard A. Harpootlian, Esquire
Graham L. Newman, Esquire
Richard A. Harpootlian, P.A.
1410 Laurel St.
Columbia, South Carolina 29202
Attorney for Plaintiff

Carey M. Ayers, Esquire
Nicholson, Davis Frawley Anderson & Ayer
P. O. Box 489
Lexington, South Carolina 29071-0489
Attorney for Plaintiff

Mr. Robert C. Brown, Esquire
Brown & Brehmer
1720 Main Street
Columbia, South Carolina 29202
Attorney for Defendant

FILED
2009 SEP 28 P 12:13
BETH A. GAMBRELL
CLERK OF COURT
LEXINGTON, SC

Caroline C. Tiffin, Esquire
526 Old Saybrook Drive
Columbia, South Carolina 29210-5031
Attorney for Defendant

Ida M. Thomas

Ida M. Thomas

September 24th, 2009.



BAKER RAVENEL BENDER

ATTORNEYS AT LAW

*CHARLES E. BAKER
D. CRAVENS RAVENEL
*JAY BENDER
S. MARKEY STUBBS
CATHARINE GARBEE GRIFFIN
**WILLIAM PEARCE DAVIS
KIRBY D. SHEALY III
HOLLY PALMER BELSON
BRADLEY L. LANFORD
SAMUEL M. MOKEBA
EMMA ISABELLE BRYSON
BROOK BRISTOW
DANIELLE E. PAYNE
*OF COUNSEL
**ALSO ADMITTED IN GEORGIA

September 24, 2009

The Honorable Beth A. Carrigg
Lexington County Clerk of Court
205 E. Main St.
Lexington, South Carolina 29072-3494

Re: Michael Russell and Susanne Russell v. Connie Collins
C/A No.: 2008-CP-32-03411
Our File No.: 7746.1691

Dear Ms. Carrigg:

Please find enclosed for filing a notice of appearance in the above-referenced matter. I have enclosed an additional copy along with a self-addressed, stamped envelope for your convenience in returning a clocked-in copy to me. By copy hereof, I am serving the same upon all counsel. Thank you for your help in this matter.

Sincerely,

Kirby D. Shealy III

KDSIII:imt
Enclosure

cc: Richard A. Harpootlian, Esquire
Graham L. Newman, Esquire
Robert C. Brown, Esquire
Caroline C. Tiffin, Esquire
Carey M. Ayers, Esquire
Ms. Lee Sheorn

FILED
2009 SEP 28 P 12:13
BETH A. CARRIGG
CLERK OF COURT
LEXINGTON, SC

BAKER, RAVENEL & BENDER, L.L.P.
www.brblegal.com
mail PO BOX 8057 | COLUMBIA, SC 29202
shipping 3710 LANDMARK DRIVE, suite 400 | COLUMBIA, SC 29204
phone 803 799 9091 | fax 803 779 3423

SCANNED

STATE OF SOUTH CAROLINA	COURT OF COMMON PLEAS
COUNTY OF LEXINGTON	ELEVENTH JUDICIAL CIRCUIT
	Civil Action No.: 08-CP-32-03411
Michael Russell and Susanne Russell,	
Plaintiffs,	
Vs.	**PLAINTIFF'S MICHAEL RUSSELL'S REPLY TO DEFENDANT'S COUNTERCLAIM**
Connie Collins.,	
Defendants.	

The Plaintiff Michael Russell replying to the Defendant's Counterclaim herein would respectfully show onto the Court that:

FOR A FIRST DEFENSE

1. The Plaintiff denies each and every allegation of the Defendant's Answer and Counterclaim not hereinafter specifically admitted.
2. The Plaintiff realleges each and every allegation of the Plaintiff's Complaint as fully as if set forth verbatim herein and denies each and every allegation of the Defendant's Answer and Counterclaim inconsistent therewith.
3. The Plaintiff admits the allegations contained in Paragraph 17 of the Counterclaim wherein it is alleged that on June 18, 2008 at approximately 9:24 p.m. while it was dark the Plaintiff was driving his 1998 Harley Davidson motorcycle in an easterly

direction on Interstate I-26 in Lexington County. Plaintiff admits that he was wearing Costa Del Mar glasses at the time of the wreck. The Plaintiff denies the remaining allegations contained in Paragraph 17 of the Counterclaim.

4. In response to Paragraph 18 of the Counterclaim, the Plaintiff realleges every allegation of its Complaint relating to the conduct and behavior of the Defendant, Connie Collins. The Plaintiff admits that on June 18, 2008 at approximately 9:24 p.m., the Defendant Connie Collins' vehicle was located on the 115 Exit ramp of Interstate I-26. In further responding to the allegations contained in Paragraph 18 of the Counterclaim, Plaintiff denies that he ran the Harley Davidson motorcycle into the right rear of the vehicle the Defendant was driving at a high rate of speed and while under the influence of alcohol , drugs or other intoxicating substances. In further responding to the allegations contained in Paragraph 18 of the Counterclaim, the Plaintiff is without sufficient information to form an opinion of belief as to the remaining allegations contained in Paragraph 18 of the Counterclaim and therefore denies same.

5. The Plaintiff denies the allegations contained in Paragraph 19 (a-m), 20 and 21 of the Counterclaim.

FOR A SECOND DEFENSE

6. Any injuries or damages sustained by the Defendant were due wholly and solely to the negligence, carelessness, recklessness, gross negligence, willfulness and wantonness of the Defendant, and without which such injuries or damages would not have occurred; Plaintiff pleads such negligence, carelessness, recklessness, gross negligence, willfulness and wantonness on the part of the Defendant and would ask

that the Court compare the acts of the parties and if it is determined that the Defendant's negligence, carelessness, recklessness, gross negligence, willfulness and wantonness is greater than the negligence, carelessness, recklessness, gross negligence, willfulness and wantonness of the Plaintiff then the Defendant should be totally barred from recovery, and if it is determined that the Defendant's negligence, carelessness, recklessness, gross negligence, willfulness and wantonness is less than that of the Plaintiff then the amount of the recovery available to the Defendant should be reduced by the percentage of the Defendant's own negligence, carelessness, recklessness, gross negligence, willfulness and wantonness.

WHEREFORE, having fully replied to the Counterclaim, Plaintiff respectfully prays that the relief prayed for in the Plaintiff's Complaint be granted and that the Defendant's Counterclaim be dismissed and that the Plaintiff be granted the relief set forth in the Complaint herein and that the Counterclaim herein be dismissed with costs, and for such other and further relief as this Court may deem just and proper.

NICHOLSON, DAVIS, FRAWLEY, ANDERSON, & AYER, LLC

By: _____

Carey M. Ayer, Esquire
140 East Main Street, Post Office Box 489
Lexington, South Carolina 29072
Phone No.: (803) 359-2512
ATTORNEY FOR MICHAEL RUSSELL

RICHARD A. HARPOOTLIAN, P.A.

By: Richard A. Harpootlian by Cay H.G.
Richard A. Harpootlian, Esquire

By: Graham L. Newman by Cay H.G.
Graham L. Newman, Esquire
P.O. Box 1090
Columbia, SC 29202
(803) 252-4848
ATTORNEYS FOR PLAINTIFFS, MICHAEL RUSSELL AND SUSANNE RUSSELL

October 20, 2008
Lexington, South Carolina

CERTIFICATE OF SERVICE BY MAIL

Docket No. 2008-CP-32-03411

2008 OCT 30 P 2:42

I, Cherie Drumm, an employee of Nicholson, Davis, Frawley, Anderson & Ayer, L.L.P. hereby certifies that I have served the foregoing Plaintiff's Michael Russell's Reply to Defendant's Counterclaim, by mailing a copy of each, postage prepaid and return address clearly indicated on said envelope, to the following addresses:

Robert C. Brown, Esq.
Brown & Brehmer
P.O. Box 7966
Columbia, SC 29202

Caroline Callison Tiffen, Esq.
McWhirter, Bellinger & Associates
1807 Hampton St.
Columbia, SC 29201

on this 30th day of October, 2008, all in accordance with Rule 5(b)(1) of the South Carolina Rules of Civil Procedure.

NICHOLSON, DAVIS, FRAWLEY, ANDERSON AND AYER, LLC

by: Cherie Drumm

Cherie Drumm
140 East Main Street, P. O. Box 489
Lexington, South Carolina 29071
(803) 359-2512

Lexington, South Carolina

ORIGINAL

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF LEXINGTON)	ELEVENTH JUDICIAL CIRCUIT
Michael Russell and)	Civil Action No. 2008-CP-32-03411
Susanne Russell,)	
)	
Plaintiffs,)	
)	
Vs.)	STIPULATION OF DISMISSAL
)	
Connie Collins,)	
)	
Defendant)	

SCANNED

The above-referenced matter, having been settled between the parties, the undersigned as attorneys for the parties herein, hereby stipulate that it be dismissed with prejudice and forever ended.

LMC

RICHARD A. HARPOOTLIAN, PA

Richard A. Harpootlian
Attorney for Plaintiff
PO Box 1090
Columbia, SC 29292

BROWN & BREHMER

Robert C. Brown
1720 Main Street, Suite 201
Post Office Box 7966
Columbia, South Carolina 29202
(803) 771-6600
Attorneys for Defendant

EH

July 17, 2009

BROWN & BREHMER
Attorneys at Law
1720 MAIN STREET, SUITE 201
POST OFFICE BOX 7966,
COLUMBIA, SOUTH CAROLINA 29202
TELEPHONE: (803) 771-6600
FACSIMILE: (803) 252-1620

ROBERT C. BROWN
KARL S. BREHMER
CHAD E. POTEAT
E. DALE LANG, JR.
J. AUSTIN HOOD
L. DARBY PLEXICO, III
ELY O. GROTE

OF COUNSEL
MICHAEL M. LUMPKIN

E-MAIL
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BOB.BROWN@BROWNANDBREHMER.COM
KARL.BREHMER@BROWNANDBREHMER.COM
CHAD.POTEAT@BROWNANDBREHMER.COM
DALE.LANG@BROWNANDBREHMER.COM
AUSTIN.HOOD@BROWNANDBREHMER.COM
LDP@BROWNANDBREHMER.COM
ELY.GROTE@BROWNANDBREHMER.COM

July 23, 2009

The Honorable Beth Carrigg
Clerk of Court, Lexington County
Lexington County Judicial Center
205 East Main Street
Lexington, SC 29072

RE: Russell v. Collins
Civil Action No. 2008-CP-32-3411

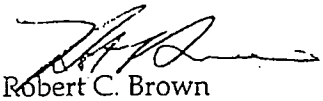
Dear Ms. Carrigg:

Enclosed please find the original and one copy of a Stipulation of Dismissal pursuant to the above referenced matter. Please file the original and return a clocked in copy to this office in the enclosed self addressed stamped letter.

By copy of this letter to Richard Harpootlian, Esquire, I am advising him of this communication with the Court.

With warmest personal regards, I am

Very truly yours,



Robert C. Brown

EH

RCB/gch
Enclosures

Cc: Richard Harpootlian, Esquire

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2008CP3203411

Michael Russell *vs.* Connie Collins

CHECK ONE:

☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ ACTION DISMISSED (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other:

☐ ACTION STRICKEN (*CHECK REASON*): ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:

☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: _____

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Court Reporter:

PRESIDING JUDGE -

This judgment was entered on the N/A, and a copy mailed first class this 28th day of July, 2009, to attorneys of record or to parties (when appearing pro se) as follows:

Richard A. Harpootlian
Richard A. Harpootlian, PA
P.O. Box 1090 Columbia, SC 29202

ATTORNEY(S) FOR THE PLAINTIFF(S)

Robert C. Brown
Brown & Brehmer
P.O. Box 7966, Columbia, SC 29202

ATTORNEY(S) FOR THE DEFENDANT(S)

Beth A. Carrigg/lc

Beth A. Carrigg - Clerk of Court

SCRCP APP-24/FORM 4

CPFORM4M

ORIGINAL

SCANNED

STATE OF SOUTH CAROLINA COUNTY OF LEXINGTON Michael Russell and Susanne Russell, Plaintiffs, vs. Connie Collins, Defendant.	IN THE COURT OF COMMON PLEAS ELEVENTH JUDICIAL CIRCUIT Civil Action No.: 2008-CP-32-03411 AMENDED STIPULATION OF DISMISSAL LMC

The Plaintiffs' actions against the Defendant having been settled between the parties, the undersigned as attorneys for the parties herein, hereby stipulate that the Plaintiffs' action against the Defendant be dismissed with prejudice and forever ended. This Stipulation of Dismissal shall in no way affect the Defendant's action by way of Counterclaim against the Plaintiffs for purposes of pursuing an Underinsured Motorist claim in this matter.

RICHARD A. HARPOOTLIAN, PA

Richard A. Harpootlian
Post Office Box 1090
Columbia, South Carolina 29292
Attorney for Plaintiffs

BROWN & BREHMER

Robert C. Brown
1720 Main Street, Suite 201
Post Office Box 7966
Columbia, South Carolina 29202
(803) 771.6600
Attorneys for Defendant

September 18, 2009

FILED
2009 SEP 28 P 12: 22
BETH A. GARRIGG
CLERK OF COURT
LEXINGTON, SC

BROWN & BREHMER
Attorneys at Law
1720 MAIN STREET, SUITE 201
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TELEPHONE: (803) 771-6600
FACSIMILE: (803) 252-1620

ROBERT C. BROWN
KARL S. BREHMER
CHAD E. POTEAT
E. DALE LANG, JR.
J. AUSTIN HOOD
L. DARBY PLEXICO, III
ELY O. GROTE

OF COUNSEL
MICHAEL M. LUMPKIN

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CHAD.POTEAT@BROWNANDBREHMER.COM
DALE.LANG@BROWNANDBREHMER.COM
AUSTIN.HOOD@BROWNANDBREHMER.COM
LDP@BROWNANDBREHMER.COM
ELY.GROTE@BROWNANDBREHMER.COM

September 25, 2009

The Honorable Beth Carrigg
Lexington County Clerk of Court
Lexington County Judicial Center
205 East Main Street
Lexington, South Carolina 29072

RE: *Russell vs. Collins*
Civil Action No.: 2008-CP-32-3411

Dear Ms. Carrigg:

Please find enclosed the original and one copy of the Amended Stipulation of Dismissal in connection with the above referenced matter. I would ask that you please file the original and return the clocked in copy to me in the enclosed self-addressed stamped envelope, which has been provided for your convenience.

By copy of this letter to Richard Harpootlian, Esquire, I am advising him of this communication with the Court.

With warm personal regards, I am

Sincerely yours,

Robert C. Brown

RCB:twc
Enclosure(s)
cc: Richard Harpootlian, Esquire (w/out enclosure)

FILED
2009 SEP 28 P 12: 22
BETH A. CARRIGG
CLERK OF COURT
LEXINGTON, SC

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2008CP3203411

Michael Russell *vs.* Connie Collins

CHECK ONE:

☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ ACTION DISMISSED (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other:

☐ ACTION STRICKEN (*CHECK REASON*): ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:

☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: _____

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Dated at Lexington, South Carolina, this .

Court Reporter:

_____

PRESIDING JUDGE -

This judgment was entered on the N/A, and a copy mailed first class this 29th day of September, 2009, to attorneys of record or to parties (when appearing pro se) as follows:

Richard A. Harpootlian
Richard A. Harpootlian, PA
P.O. Box 1090 Columbia, SC 29202

ATTORNEY(S) FOR THE PLAINTIFF(S)

Robert C Brown
Brown & Brehmer
PO Box 7966 Columbia, SC 29202

ATTORNEY(S) FOR THE DEFENDANT(S)

Beth A. Carrigg/lc

Beth A. Carrigg - Clerk of Court

SCRCP APP-24/FORM 4

CPFORM4M

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)

Michael Russell and)
Susanne Russell,)

Plaintiffs,)

Vs.)

Connie Collins.,)

Defendants.)

COURT OF COMMON PLEAS
ELEVENTH JUDICIAL CIRCUIT

Civil Action No.: 08-CP-32-03480

ORIGINAL
FILED
2009 OCT -8 P 3:14
BETH A. CARRIGG
CLERK OF COURT
LEXINGTON SC

SCANNED

EH

SUBSTITUTION OF COUNSEL

CAREY M. AYER defended the Counterclaim of Connie Collins and has filed a Reply on behalf of Michael Russell, and Carey M. Ayer now wishes to be substituted as counsel, and Kirby D. Shealy, III agrees to be substituted as counsel replacing Carey M. Ayer in the defense of this Counterclaim.

IT IS NOW ORDERED that Kirby D. Shealy, III be substituted as counsel for Carey M. Ayer in the defense of the referenced Counterclaim

I SO MOVE:

Carey M. Ayer

I SO CONSENT:

Kirby D. Shealy, III

IT IS SO ORDERED.

The Honorable
Chief Administrative Judge, 11th Judicial Circuit

Lexington, South Carolina
September 9, 2009

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2008CP3203411

Michael Russell *vs.* Connie Collins

CHECK ONE:

☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ ACTION DISMISSED (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other:

☐ ACTION STRICKEN (*CHECK REASON*): ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:

☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: _____

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Dated at Lexington, South Carolina, this .

Court Reporter:

PRESIDING JUDGE -

This judgment was entered on the n/a, and a copy mailed first class this 12th day of October, 2009, to attorneys of record or to parties (when appearing pro se) as follows:

Richard A. Harpootlian Richard A. Harpootlian, PA P.O. Box 1090 Columbia, SC 29202
Carey M Ayer Nicholson Davis et al LLC PO Box 489 Lexington, SC 29071
Kirby D Shealy III Baker Ravenel & Bender Llp P O Box 8057 Columbia, SC 29202

ATTORNEY(S) FOR THE PLAINTIFF(S)

Robert C Brown Brown & Brehmer PO Box 7966 Columbia, SC 29202

ATTORNEY(S) FOR THE DEFENDANT(S)

Beth A. Carrigg/eh

CPFORM4M

ORIGINAL

OCT 08 REC'D

FILED

2009 OCT -8 P 3:18

BETH A. CARRIGG
CLERK OF COURT
LEXINGTON SC

NICHOLSON, DAVIS, FRAWLEY, ANDERSON & AYER, LLC

ATTORNEYS AND COUNSELORS AT LAW

OLD COURTHOUSE PLACE 140 E. MAIN ST
POST OFFICE BOX 489
LEXINGTON, SOUTH CAROLINA 29071-0489

TELEPHONE (803) 359-2512
FACSIMILE (803) 359-7478

E-MAIL: lisa@oldcourthouse.com
DIRECT LINE: (803) 951-7411

GEORGE S. NICHOLSON, JR.*
JAMES RANDALL DAVIS
PATRICK J. FRAWLEY
JEFF M. ANDERSON
CAREY M. AYER
JOHN F. FISHER
JUDITH CALLISON FISHER
LISA LEE SMITH†
JOHN J. McCAULEY
RYAN M. WINGARD
A. JEWITTE DOOLEY

*Certified Circuit Court Arbitrator
†Certified Circuit Court Mediator
American Board of Trial Advocates

OF COUNSEL
ROBERT K. BOUKNIGHT

FRANCIS C. JONES
(1919 - 1968)
HUBERT E. LONG
(1921 - 2000)

October 2, 2009

Honorable Knox McMahon
Chief Administrative Judge
11th Judicial Circuit/Lexington County
205 E. Main St.
Lexington, SC 29072-3456

Re: Michael Russell, et al v. Connie Collins
Docket No. 2008-CP-32-03411
My File No.: 14612.73
SCFB Claim No.: AU210655

Dear Judge McMahon:

Please find enclosed a proposed Substitution of Counsel for your consideration in the above referenced matter. If this document meets your approval, please sign and return to me for filing with the Clerk's office.

Thank you for your assistance.

Sincerely,

Carey M. Ayer
CMA/ctd

cc: Billy Higginbotham
Mike Rogers
Kirby Shealy, III, Esquire

No Envelope enclosed! PCH

ORIGINAL

SCANNED

LMC

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF LEXINGTON	C/A NO.: 2008-CP-32-03411
Michael Russell and Susanne Russell, Plaintiffs, v. Connie Collins, Defendant.	**STIPULATION OF DISMISSAL WITH PREJUDICE**

Pursuant to Rule 41 (a)(1)(B) of the *South Carolina Rules of Civil Procedure*, the undersigned hereby represent to the Court that the only remaining claim in this matter is the counterclaim of Connie Collins in which she seeks underinsured motorist coverage under her own policy. The undersigned further stipulate that Connie Collins' claim has now been resolved that this matter shall be and hereby is dismissed with prejudice.

WE SO STIPULATE:

Caroline Callison Tiffin
McWhirter, Bellinger & Associates, P.A.
1807 Hampton Street
Columbia, South Carolina 29201
(803) 252-5522
Attorneys for Defendant

FILED
2008 NOV 12 P 12:05
BETH A. [illegible]
CLERK OF COURT
LEXINGTON, SC

WE SO STIPULATE:

Kirby D. Shealy III
BAKER, RAVENEL & BENDER, L.L.P.
3710 Landmark Drive, Suite 400

Post Office Box 8057
Columbia, South Carolina 29202
(803) 799-9091
Attorneys for Travelers Home and Marine Insurance Company, a purported underinsured Motorist carrier for the defendant

STATE OF SOUTH CAROLINA

COUNTY OF LEXINGTON

IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE

CASE NO: 2008CP3203411

Michael Russell *vs.* Connie Collins

CHECK ONE:

☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

☐ ACTION DISMISSED (*CHECK REASON*): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other:

☐ ACTION STRICKEN (*CHECK REASON*): ☐ Rule 40(j) SCRCP; ☐ Bankruptcy:

☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award;
☐ Other: _____

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Court Reporter:

PRESIDING JUDGE -

This judgment was entered on the N/A, and a copy mailed first class this 17th day of November, 2009, to attorneys of record or to parties (when appearing pro se) as follows:

Kirby D Shealy III
Baker Ravenel & Bender LLP
P O Box 8057 Columbia, SC 29202

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Beth A. Carrigg/lc

SCRCP APP-24/FORM 4

Beth A. Carrigg - Clerk of Court

CPFORM4M



BAKER RAVENEL BENDER

ATTORNEYS AT LAW

*CHARLES E. BAKER
D. CRAVENS RAVENEL
*JAY BENDER
S. MARKLEY STUBBS
CATHARINE CARBEE GRIFFIN
**WILLIAM PEARCE DAVIS
KIRBY D. SHEALY III
HOLLY PALMER BEESON
BRADLEY L. LANFORD
SAMUEL M. MOKEBA
EMMA ISABELLE BRYSON
BROOK BRISTOW
DANIELLE F. PAYNE
*OF COUNSEL
**ALSO ADMITTED IN GEORGIA

November 10, 2009

FILED
2009 NOV 12 P 12:05
BETH A. CARRIGG
CLERK OF COURT
LEXINGTON, SC

The Honorable Beth A. Carrigg
Lexington County Clerk of Court
205 E. Main St.
Lexington, South Carolina 29072-3494

Re: Michael Russell and Susanne Russell v. Connie Collins
C/A No.: 2008-CP-32-03411
Our File No.: 7746.1691

Dear Ms. Carrigg:

I enclose the stipulation of dismissal with prejudice in the above-referenced matter that has been signed by myself and Caroline Tiffin. We are the only lawyers representing clients with a remaining interest in the above-referenced lawsuit. This case is now dismissed outright.

I have enclosed a self-addressed, stamped envelope for your use in returning the enclosed copy of the stipulation of dismissal after it has been file-stamped. Thank you for your attention to this matter.

Sincerely,

Kirby D. Shealy III

KDSIII:tfk
Enclosures

cc: Caroline C. Tiffin, Esquire (w/enclosure)
Ms. Lee Sheorn (via email, w/enclosure)

BAKER, RAVENEL & BENDER, L.L.P.
www.brblegal.com.
mail. PO BOX 8057 | COLUMBIA, SC 29202
shipping. 3710 LANDMARK DRIVE. suite 400 | COLUMBIA, SC 29204
phone. 803.799 9091 | fax. 803.779 3423

Mail FR-10 to: SC Department of Motor Vehicles
Office of Financial Responsibility (803) 896-5000
PO Box 1498, Blythewood, SC 29016

South Carolina Department of Motor Vehicles (DMV)
FR-10 (REV. 10/05)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company Representatives can submit your insurance information at WWW.SC-ALIR.COM

Date	Time	County	Collision Location (Rt. # / Name)	Miles	Dir.	Near City or Town of
8-4-22	2124	32	1-Interstate 2-US Primary 3-SC Primary 4-Secondary 5-County 6-Connector 7-Business 8-Ramp 9-Alternate	1/4	N E S W	Conway

To Vehicle Owner/ Operator: **Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.**

FR10 Audit No. X-561055

Driver/Pedestrian's Full Name: Russell - Michael

Unit #	Sex	Race	Street
1	M	W	

Birth Date: [redacted] City, State, & Zip:

State: C | Driver's License #: [redacted] | Insurance Company:

Year	Body	Vehicle Make	VIN #
03	HWT	FO	1FDNF6P64WEB14491

State: SC | Year: 2019 | License Plate #: ZWO739 | Owner's D.L. #: 22491-90-549

Home Telephone: (843) 965 0335 | Owner's Full Name: Russell - Michael

Bus. Telephone: ( ) NA | Street: 1464 Dogwood St

Contributed To Collision: (Yes) (No) | City, State, & Zip: Conway SC

FR10 Audit No. X-561056

Driver/Pedestrian's Full Name: Collins - Connie Lynn

Unit #	Sex	Race	Street
2	F	W	

Birth Date: [redacted] City, State, & Zip:

State: SC | Driver's License #: [redacted] | Insurance Company: Travelers

Year	Body	Vehicle Make	VIN #
2022	4S	HYUN	KMHD84LF1NU281[illegible]7

State: SC | Year: 2022 | License Plate #: SDJ7871 | Owner's D.L. #: [redacted]

Home Telephone: ( ) | Owner's Full Name: Collins - Connie Lynn

Bus. Telephone: ( ) | Street: 1104 Starcrest

Contributed To Collision: (Yes) (No) | City, State, & Zip: Myrtle Beach SC 29572

FR10 Audit No. X-561057

Driver/Pedestrian's Full Name:

Unit #	Sex	Race	Street

Birth Date: City, State, & Zip:

State: Driver's License #: Insurance Company:

Year	Body	Vehicle Make	VIN #

State: Year: License Plate #: Owner's D.L. #:

Home Telephone: Owner's Full Name:

Bus. Telephone: Street:

Contributed To Collision: (Yes) (No) City, State, & Zip:

All Units Insurance Information
(to be completed by investigating officer)

Automobile Liability Insurance Information for Unit #:
Company Name: Travelers | Area Code/Phone Number: (860) 184-3675
Agency Name: ONEBEACH | Policy Number: [redacted]

Automobile Liability Insurance Information for Unit #:
Company Name: | Area Code/Phone Number: ( )
Agency Name: | Policy Number:

Automobile Liability Insurance Information for Unit #:
Company Name: | Area Code/Phone Number: ( )
Agency Name: | Policy Number:

Automobile Liability Insurance Information for Unit #:
Company Name: | Area Code/Phone Number: ( )
Agency Name: | Policy Number:

Automobile Liability Insurance Information

Notice of Requirement Accepted | Signature: | VIN Refused to Affix Signature? | VIN Vehicle Subject to Registration in SC?

To Be Completed Below or Entered at WWW.SC-ALIR.COM By Insurance Company Representative. This section should not be required by DMV if insurance information has been submitted electronically.

The information contained herein is based solely upon my knowledge and belief as a representative of the above insurance company and is complete to the extent of information supplied to me by the above-mentioned insured as of date hereof.

In reference to Unit #: I hereby affirm that to the best of my knowledge the vehicle described above was insured by the below stated insurance company on the date of the collision.

Insurance Company: | Policy #: | Signature: | Title:

Beginning Date: | Ending Date: | Policy Holder: | NAIC# (Assigned by S.C. Dept. of Ins.) | Bus. Telephone

Notice: If liability insurance was not in effect for your vehicle involved in the collision, The Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, disregard the above portion:

Form FR-10 Not Issued: Section 56-10-520

- Check here if a Form SR-22 Filed: Policy of 25 or more vehicles (on file with the Department of Motor Vehicles)
- Check here if a Certificate of Self-Insurance was issued by the Department of Motor Vehicles
- Check here if Liability Insurance was not in effect at the time of the collision and a Uniform Traffic Ticket was issued

No. FR-10 Issued to Operator/Owner of Unit #:
Summons Issued to:
For operating or allowing the operation of an uninsured vehicle
Summons Number:
Signature: | Date:
Signature:

Investigating Officer's Name: [illegible] | Rank: Trp | Badge #: 720 | Code: HTY | Date: 08-19-22
Reviewer's Name: | Rank: | Internal Agency Code:

DEFENDANT'S EXHIBIT 202
8
Pgs 1 of 2

PLIC 0369

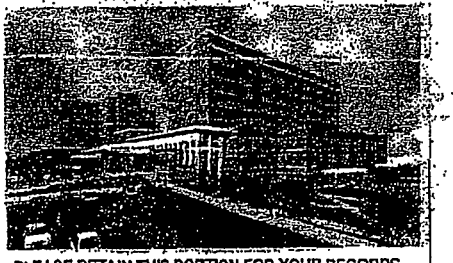
YOUR STATEMENT

Your insurance company has processed your claim and the balance is your responsiblity. Please pay the balance in full or call Customer Service if you have any questions.

10237-P555

SUMMARY OF CHARGES

110 PRIVATE ROOM & BOARD	525.00
250 PHARMACY GENERAL	3048.73
258 PHARMACY IV SOLUTIONS	549.00
259 PHARMACY OTHER	174.25
270 M/S SUPPLY GENERAL	1851.09
272 M/S SUPPLY STERILE SUPPLY	1890.92
300 LABORATORY GENERAL	26.00
301 LABORATORY CHEMISTRY	367.00
302 LABORATORY IMMUNOLOGY	119.00
305 LAB HEMATOLOGY	420.00
320 RADIOLOGY DIAG GENERAL	2718.00
323 RADIOLOGY DIAG ARTERIOGR	1281.00
360 OR SVCS GENERAL	6237.00
361 OR SVCS MINOR SURGERY	658.00
370 ANESTHESIA GENERAL	1464.00
371 ANESTHESIA INCIDENT TO RAD	182.00
450 EMERGENCY ROOM GENERAL	3168.00
636 DRUG SPEC ID DETAIL CODING	34.00
710 RECOVERY ROOM GENERAL	1074.00
730 EKG/ECG GENERAL	261.00
964 PROF FEES ANESTHETIST CRNA	1785.00
981 PROF FEES EMERGENCY ROOM	2289.00
985 PROF FEES EKG	72.00
Billed charges to date:	30185.99



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

INSURANCE INFORMATION

BLUE CHOICE/COMPANION ZCL30241197

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 835-0978, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	07/23/08
Patient Name:	MICHAEL C RUSSELL
Date of Service:	06/20/08
Account Number:	[redacted]
Total Charges:	30185.99
Insurance Payments Received:	-10938.07
Adjustments to Insurance:	-16736.02
Patient Payments Received:	0.00
This is your balance:	2511.90

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
08/07/2008	07/23/08	[redacted]

AMOUNT DUE	SHOW AMOUNT PAID HERE
2511.90	$

651741

PAGE: 1 of 1

0101

MICHAEL C RUSSELL

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*TF90HAG6T000142

[redacted]

DEFENDANT'S EXHIBIT 10 Russell 5/21/10

PLIC 0366

PALMETTO HEALTH RICHLAND
293 Greystone Blvd
First Floor
Columbia, SC 29210

A

CARD NUMBER	EXP. DATE
FULL NAME (Please Print)	CCV CODE
SIGNATURE	
PATIENT NAME AND ACCOUNT NUMBER: MICHAEL C RUSSELL [redacted]	DATES OF SERVICE: 06/20/2008 - 07/01/200
ACCOUNT BALANCE: $77,387.21	TOTAL CHARGES: $77,387.21
AMOUNT PAID: $	

STATEMENT DATE: 07/06/08 PAGE: 1 of 1

ADDRESSEE
MICHAEL C RUSSELL

REMIT TO
PALMETTO HEALTH RICHLAND
C/O PAYMENT PROCESSING
PO BOX 402111
ATLANTA, GA 30384-2111

Please detach and return this portion with payment.

Dear Michael C Russell:

*** THIS IS NOT A BILL ***

Thank you for choosing Palmetto Health Richland as your healthcare provider.

This statement is a summary of charges and shows the insurances that will be billed on your behalf. Please review the insurance information located at the bottom right of this statement for accuracy and notify us of any changes that need to be made. Changes may be entered on the back of this form in the About Your Insurance Section, located above the Summary of Charges, and returned to us in the enclosed envelope or you may contact our Customer Service Representatives at 803-296-5098 or 800-243-7711.

Customer Service Representatives are available to assist you Monday through Friday from 8:30 a.m. to 5:00 p.m.. Palmetto Health offers financial assistance to the under insured or uninsured.
AR

➤ ACCOUNT SUMMARY

Statement Date:	07/06/08
Service Date(s):	06/20/2008 - 07/01/2008
Account Number:	[redacted]
Account Balance:	**$77,387.21**

➤ INSURANCE INFORMATION

Contact us if any of this information is incorrect. Please note only primary and secondary insurances are listed on this statement.

PRIMARY
Insurance: BLUE CHOICE HEALTHPLA
Name of Insured: MICHAEL C RUSSELL
ID Number: [redacted]

SECONDARY
Insurance:
Name of Insured:
ID Number:



Para Asistencia en Español llamar a 800-243-7711

PLEASE SEE REVERSE SIDE

PLIC 0367

IF ANY OF THE FOLLOWING IS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE ( ) MARITAL STATUS ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMPLOYER'S NAME TELEPHONE ( )

EMPLOYER'S ADDRESS CITY STATE ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME

PRIMARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICY HOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE COMPANY'S NAME

SECONDARY INSURANCE COMPANY'S ADDRESS PHONE

CITY STATE ZIP

POLICY HOLDER'S ID NUMBER GROUP PLAN NUMBER

HOSPITAL SUMMARY OF CHARGES

Description	Amount	Description	Amount
ROOM AND BOARD	7535.00	SELF ADMINISTERED DRUGS	858.50
PHARMACY/GENERAL	2286.00	CAST ROOM	264.00
MED/SUR SUPPLIES	2333.00	RECOVERY ROOM	2043.00
NONSTERILE SUPPLY	47.00	PRO FEE/ANES RN	4368.00
STERILE SUPPLY	408.00	UNIDENTIFIED	0.00
SUPPLY IMPLANTS	10077.71	TOTAL CHARGES	77387.21
LABORATORY	220.00		
LAB/IMMUNOLOGY	808.00	TOTAL INSURANCE PAYMENTS	0.00
LAB/HEMATOLOGY	597.00	TOTAL ADJUSTMENTS	0.00
PATH/HISTOL	385.00	TOTAL PATIENT PAYMENTS	0.00
DX X-RAY	1391.00		
CT SCAN/BODY	1947.00	ACCOUNT BALANCE	77387.21
OR SERVICES	21421.00		
OR SERVICES/MINOR	713.00		
ANESTHESIA	5203.00		
BLOOD/STOR-PROC	888.00		
PHYSICAL THERAPY	885.00		
PHYS THERAPY/EVALUATION	646.00		
EPO/DRUGS REQUIRING DET CODE	12063.00		

Date(s) of Service	Location	Account Number
06/20/2008 - 07/01/2008	R INPATIENT	[redacted]

Customer Service

If you have any questions regarding this balance or would like an itemized statement, please contact our Patient Financial Services at 803-296-5098 or 800-243-7711. Monday through Friday, 8:30 a.m. to 5:00 p.m.. You may email questions to us at: www.palmettohealth.org. Written correspondence - Palmetto Health Richland, C/O Payment Processing, PO Box 402111, Atlanta, GA 30384-2111

Other Bills You May Receive

You may receive bills from your own doctor, doctors who assisted in your care, or from other facilities. The doctors and facilities bill for their services separately, and may include:

Radiology:	(803) 434-2600
Pathology:	(866) 252-1913
Anesthesiology:	(803) 434-6151
ER Doctor Billing:	(800) 877-7564

PLIC 0368

Mail FR-10 to: SC Department of Motor Vehicles
Office of Financial Responsibility (803) 896-5000
PO Box 1498, Blythewood, SC 29016

South Carolina Department of Motor Vehicles (DMV)
FR-10 (REV. 10/05)
NOTICE OF REQUIREMENT

Submit Electronically: Agents or Company Representatives can submit your insurance information at WWW.SCALIR.COM

Date	Time	County	Collision Location (Rt. # / Name)	Miles:	Dir.	Int. Near City or Town of:
9-4-09	2121	1- Interstate 4- Secondary 2- US Primary 5- County 3- SC Primary	8 26	N/A	N E S W	Cayce

To Vehicle Owner/ Operator: **Failure to return this form to the Department of Motor Vehicles within 15 days from the date of the collision could result in the suspension of your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.**

FR10 Audit No. X-561055

Driver/Pedestrian's Full Name: Russell - Michael

Unit # 1 | Sex M | Race W | Street: [redacted]

Birth Date: [redacted] | City, State, & Zip: [redacted]

State SC | Driver's License #: [redacted] | Insurance Company: [redacted]

Year 99 | Body MVT | Vehicle Make: [illegible] | VIN #: [redacted]

State SC | Year 2009 | License Plate #: ZWO 739 | Owner's D.L. #: [redacted]

Home Telephone: (843) 965 0335 | Owner's Full Name: Russell - Michael

Bus. Telephone: ( ) N/A | Street: [redacted]

Continued To Collision: [redacted]

FR10 Audit No. X-561056

Driver/Pedestrian's Full Name: Collins - Connie Lynn

Unit # 2 | Sex F | Race W | Street: [redacted]

Birth Date: [redacted] | City, State, & Zip: [redacted]

State SC | Driver's License #: [redacted] | Insurance Company: Progressive

Year 2006 | Body SU | Vehicle Make: HYUN | VIN #: [redacted]

State SC | Year 2009 | License Plate #: 553 TBH | Owner's D.L. #: [redacted]

Home Telephone: ( ) | Owner's Full Name: Collins - Connie Lynn

Bus. Telephone: ( ) | Street: [redacted]

Continued To Collision: [redacted]

FR10 Audit No. X-561057

Driver/Pedestrian's Full Name: [redacted]

Unit # [redacted] | Sex [redacted] | Race [redacted] | Street: [redacted]

Birth Date: [redacted] | City, State, & Zip: [redacted]

State [redacted] | Driver's License #: [redacted] | Insurance Company: [redacted]

Year [redacted] | Body [redacted] | Vehicle Make: [redacted] | VIN #: [redacted]

State [redacted] | Year [redacted] | License Plate #: [redacted] | Owner's D.L. #: [redacted]

Home Telephone: [redacted] | Owner's Full Name: [redacted]

Bus. Telephone: [redacted] | Street: [redacted]

Continued To Collision: [redacted]

All Units Insurance Information
(to be completed by Investigating Officer)

Automobile Liability Insurance Information for Unit #

Company Name: TRAVELERS | Area Code/Phone Number: (860) 184-3675

Agency Name: [redacted] | Policy Number: [redacted]

Automobile Liability Insurance Information for Unit #

Company Name: [redacted] | Area Code/Phone Number: ( )

Agency Name: [redacted] | Policy Number: [redacted]

Automobile Liability Insurance Information

Notice of Requirement Accepted | Signature: [redacted] | Y/N Refused to Affix Signature? | Y/N Vehicle Subject to Registration in SC?

This Completed Online or Entered at WWW.SCALIR.COM by Insurance Company Representative. The [illegible] provided to DMV. If insurance information has been submitted electronically, [illegible] this signature, as contained herein is based solely upon my knowledge and belief as to the [illegible] of the above insurance company and its [illegible]

In reference to Unit #: ( ) I/we hereby affirm that to the best of my knowledge the vehicle described above is insured by the below stated insurance company on the date of the collision.

Insurance Company: [redacted] | Policy #: [redacted] | Signature of Insured: [redacted] | Title: [redacted]

Beginning Date: [redacted] | Ending Date: [redacted] | Policy Holder: [redacted] | NAIC # (Assigned by S.C. Dept. of Ins.): [redacted] | Bus. Telephone: [redacted]

Notice: If liability insurance was not in effect for your vehicle involved in the collision, The Department of Motor Vehicles could suspend your driver license and registration privileges pursuant to South Carolina Code of Laws 56-9-351 and 56-10-530.

If any of the below are applicable, disregard the above portion.

- Check here if a Form SR-22 Financial Responsibility Filing for motor vehicle is on file with the Department of Motor Vehicles covering the vehicle.
- Check here if a Certificate of Self-Insurance has been issued by the Department of Motor Vehicles covering the vehicle and indicate the certificate's number: [redacted]
- Check here if Liability Insurance was not in effect at the time of the collision but is in effect at present and I/we will comply with Section 56-10-520 by placing liability insurance in effect.

Signature: [redacted] | Date: [redacted]

Form FR-10 Not Issued: Section 56-10-520

No FR-10 Issued to Operator/ Owner of Unit #:

Summons Issued to:

For operating or allowing the operation of an uninsured vehicle | Summons Number: [redacted] | Signature: [redacted]

Investigating Officer's Name	Rank	Badge #	Code	Date	Reviewer's Name	Rank	Internal Agency Code
[redacted]	Trf	720	HT	9-6-09			

PLIC 0369

0809-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 V MIKE RUSSELL

IMPORTANT 8050
1. Print Clearly & answer all questions
2. If you need additional room to complete a question, attach a sheet of paper.
3. SIGN BOTTOM OF FORM

AUGUST 14, 2008

CLAIMANT'S NAME: Michael C. Russell Soc.Sec.Num: [redacted]

Date of Birth: [redacted] Home Phone: 803-955-0329 Work Phone: 803-513-0575

Are you receiving or applying for Worker's Compensation, Unemployment Compensation or other Disability benefits? YES____NO✓? If YES, please provide the name and address of the company(ies) and the policy number(s).

Employer Name: MCR Construction LLC Employer Address: 1469 Dogwood Rd. West Columbia, SC 29172

Occupation: Owner of Company-Construction Monthly Gross Earnings: $ 4300

Job Duties: Owner, Vinyl siding application.

Were you working before you became disabled? YES✓ NO____ If NO, what were you doing?____

If you are self-employed, is your business still operating? YES✓ NO____ If NO, when did it stop?____

When did you first receive medical treatment? 6-18-08 Where? Lexington Medical Center

What is the name and address of the doctor treating you? Dr. Taquino 3 Medical Park Columbia, SC 29203

What is the name and address of any other doctors you have been referred to?____

What is the name and address of your primary/family physician? Dr. Nagel 5535 Platt Springs Rd. Lexington, SC 29073

If you were in the hospital, please give dates of confinement: Admitted 6-18-08 Discharged 7-1-08

Hospital: ~~Palmetto Health Richland~~ Lexington Medical Center Address 3720 Sunset Blvd. West Columbia SC 29169 3 Richland Medical Park Columbia, SC 29203
*(Include copy of hospital bill with this form)

Describe the sickness or injury Compound leg fracture, broken hip

If this is for a sickness condition, when did it first begin?____

If this is an accident, when and where did it happen? Date: 6-18-08 Time: 9:20 PM Place: I-26 Exit 115

Describe how it happened. Motorcycle accident

IF THIS IS A MOTOR VEHICLE ACCIDENT, PLEASE INCLUDE A COPY OF THE POLICE REPORT.

Have you ever had a similar condition in the past? YES____NO✓ If YES, please give dates, a brief description and the name and address of the doctor who treated you.____

IF EMPLOYED, did the condition above cause you to lose any time from work? YES✓ NO____ If YES, provide dates.

First Day not worked 6-19-08 What duties were you unable to do? all

When were you able to do SOME of your duties? Date:____ ALL of your duties? Date:____

IF RETIRED, A HOUSEWIFE, STUDENT OR UNEMPLOYED, did the above condition prevent you from doing your normal daily activities? YES____NO____ If YES, provide dates. First Day unable to do activities____

What activities were you unable to do?____

When were you able to do SOME of your normal activities?____

When were you able to do ALL of your normal activities?____

Did this condition cause you to be confined? YES____ NO✓ If YES, provide dates. FROM____ TO____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Pennsylvania Life Insurance Company - PO Box 12355, Pensacola, FL 32591-2355
CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE - any medical professional, medical care institution, consumer reporting agency insurance institution, insurance support organization, institution source, governmental agency including, but not limited to, the Social Security Administration and the Veterans Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agency or legal representative, and any insurance support organization and consumer reporting agency acting on The Company's behalf; with any and all medical records and personal information, requested about me or any of my minor children.
I UNDERSTAND that this Authorization will be used to obtain, information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use OT drugs or alcohol. I UNDERSTAND the information obtained by the use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy. I KNOW that I or my legal representative may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I UNDERSTAND that the duration of the Authorization is for. The term of coverage of the policy under which a claim for benefits has been submitted. If this Authorization is given in connection with a claim for disability or life insurance benefits, I UNDERSTAND that is valid for the duration of the claim.

Mike Russell 8-27-08
SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE 1052C

PLIC 0370

Attending Physician's Report

PATIENT'S NAME: Richard Russell DOB:

1. DIAGNOSIS: (Please provide ICD Code) Primary 803.0 Secondary 873.30, ,

2. Describe any other disease or infirmity affecting the present condition.	
3. When did symptoms first appear or accident happen?	DATE: 6·18·08
4. If accident, please describe.	motorcycle accident
5. When did this patient first consult you for this condition?	DATE: 6·18·08 TIME ____AM ____PM
6. Has patient ever had same or similar conditions? If YES, please state when and describe	Yes ___ No ✓
7. Please provide the name(s) and address(es) of any other treating physician(s)	
8. Provide the CPT code and date of any surgeries performed.	CPT CODE: 27759 DATE: 6·24·08 CPT CODE: 27226 DATE: 6·24·08
9. a. If hospitalized, give name and address of hospital & admission & discharge dates.	Hospital: Palmetto Richland Memorial Address 5 Medical Pk. Dr. City Columbia State SC Admitted 6·20·08 Discharged 7·1·08
b. If confined to a nursing facility, give name and address of the facility and admission and discharge dates.	Nursing Facility Address City State Admitted Discharged
10. Provide dates of treatment:	Office: 7/15/08, 8/11/08 Hospital: 6·20·08 - 7·01·08 Nursing Facility:
11. Is patient still under your care for this condition? If NO, give the date discharged from your care.	YES ✓ NO DATE:
12. How long was (or will) the patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	FROM WJ date TO: UNDETERMINED
13. How long was (or will) the patient (be) partially disabled (able to perform some but not all of his/her occupational duties)?	same as above FROM: TO:
14. If retired, housewife, student or other non-employed, please indicate a reasonable period of recovery.	No activities FROM TO Partial activities FROM TO
15. Was house confinement necessary? If YES, give dates. (see definition of "confinement" below)	YES NO ✓ FROM TO

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

REMARKS

Name of Physician: (please print)
John Iaquinto
Address: 3 Med. Pk. Dr, Ste. 330
City: Columbia
State: SC Zip: 29203

Signature:
Date: 6/27/08 Tax ID #: 582296053
Telephone #: 803·434·6958
Fax #: 803·434·8537

THANK YOU – Your time is appreciated
Pennsylvania Life Insurance Company P. O. Box 12355, Pensacola, FL 32591-2355

1052C

PLIC 0371

THU - 04 SEP A2
STANDARD OVERNIGHT
32501
FL-US
BFM

FedEx 8626 5812 4712
XH PNSA

Envt 91380 03SEP08 USCA

81

00 **FedEx. US Airbill** Express

FedEx Tracking Number 8626 5812 4712

1 From This portion can be removed for Recipient's records.

Date 9/3/08 FedEx Express Number 8626581247 12

Sender's Name NKEnvBARB Suzanne Puccoli Phone 803 252-0606

Company BARB, SNYDER & CO

Address 1751 SAINT JULIAN PL Dept./Floor/Suite/Room

City COLUMBIA State SC ZIP 29204-2409

2 Your Internal Billing Reference

3 To

Recipient's Name Phone 800 275-7366

Company Pennsylvania Life Insurance Company

Recipient's Address 411 Baylen Street Dept./Floor/Suite/Room

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City Pensacola State FL ZIP 32501

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5 Packaging

- [X] FedEx Envelope*
- [ ] FedEx Pak* Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak.
- [ ] FedEx Box
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- [ ] Other

* Declared value limit $500.

6 Special Handling — Includes FedEx services in Section 3.

- [ ] SATURDAY Delivery — Not available for FedEx Standard Overnight, FedEx First Overnight, FedEx Express Saver, or FedEx 3Day Freight.
- [ ] HOLD Weekday at FedEx Location — Not available for FedEx First Overnight.
- [ ] HOLD Saturday at FedEx Location — Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

Does this shipment contain dangerous goods? One box must be checked.

- [X] No
- [ ] Yes — As per attached Shipper's Declaration.
- [ ] Yes — Shipper's Declaration not required.
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg
- [ ] Cargo Aircraft Only

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging.

7 Payment Bill to: Enter FedEx Acct. No. or Credit Card No. below. Obtain Recip. Acct. No. [ ]

- [X] Sender — Acct. No. in Section 1 will be billed.
- [ ] Recipient
- [ ] Third Party
- [ ] Credit Card
- [ ] Cash/Check

Total Packages Total Weight Credit Card Auth.

†Our liability is limited to $100 unless you declare a higher value. See the current FedEx Service Guide for details.

8 Residential Delivery Signature Options — If you require a signature, check Direct or Indirect.

- [ ] No Signature Required — Package may be left without obtaining a signature for delivery.
- [ ] Direct Signature — Someone at recipient's address may sign for delivery. Fee applies.
- [ ] Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. Fee applies.

519

Rev. Date 10/08 Part #158278-01671 ©2008 FedEx PRINTED IN U.S.A. SRS

Field Adjuster's Report

From: Bill Maloney

Date of Dictation: November 23, 2009

Attention: Ella Lee

Date of Contact: November 18, 2009

Claimant: Mike Russell

Handled at: West Columbia, SC

Policy Number: [redacted]9360

Company: PLIC

Claim #: 0809-00062

Incurred Date: June 18, 2008

RECEIVED
DEC 04 2009
PENSACOLA DISABILITY CLAIMS

Diagnosis: Fx. Left Hip

Question involved: Update file. What are his current activities? Who is operating the business?

Residence Description

Mr. Russell resides in a rural area. His residence is a two-story home. The residence appears to be five to seven years old. The property is well maintained.
Two images were obtained of the residence/yard.

A white dual wheel flat bed truck, license tag: P381867 SC was parked on the right side of the driveway. It appeared that the vehicle had not been moved for awhile.

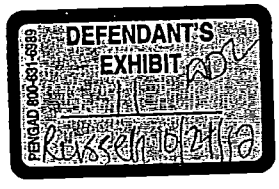
At the end of the driveway was another construction truck with several ladders on the top of the truck.

I arrived at the residence at 12:15 PM. I was parked in the driveway reviewing the file.

Shortly after I arrived, I observed a pickup truck pull in behind me. There were 3 occupants in the vehicle. The driver was Mr. Russell. The female was his wife, Susame. The other occupant was a male who appeared to be approximately 35 to 40 years of age. I was not introduced to him. This individual walked into the house. He was there for a short time and then he left. Mr. Russell had just returned from a relative's funeral in Tennessee.

Physical Description:

Mr. Russell advised that he is 5'10' and weighs 185 pounds. He was ambulating with the aid of a cane when he exited the vehicle. From a layman's observation, Mr. Russell had a distinct limp when ambulating. Mr. Russell was attired in a brown pullover T-shirt with the letters NRA on the left side of the pullover shirt and a pair of sweatpants. He was clean-shaven and had short brown hair. Other than the above description, there were no notable characteristics. See enclosed photo of Mr. Russell.



Interview:
Mr. Russell invited me into the residence. The interview took at the kitchen table. The parties present were Mr. and Mrs. Russell. Mr. Russell had no objection to his wife's presence during the interview.

Mr. Russell advised me that he was involved in a two vehicle crash on June 18, 2008. He advised me that he was driving a motorcycle and was involved in the automobile crash.

Both drivers were ticketed. The other driver took her case to court, had a jury trial and won her case. Mr. Russell's lawyer told him that it would be very costly for him to take his case to court. There are no lawsuits or third party actions pending.

Mr. Russell was first taken to Lexington Hospital after the accident. Lexington Hospital was not prepared to handle his case so he was transported to Richland Hospital, Columbia, South Carolina. He was hospital confined from June 20, 2008 to July 1, 2008.

He stated that they placed a metal plate in his left hip, and metal rods in his leg. All his injuries are on the left side. He states that he still has a plate in his pelvic bone. Mr. Russell also reported that he has a large rod in his left lower leg between the knee and the ankle.

Mr. Russell stated that he had his left hip replaced in October 2009. He said that he underwent physical therapy for approximately 2 weeks after the hip replacement. The doctor has given him home exercises to do. He stated that the left hip replacement has cut his hip pain in approximately one half. He still has problems with the left ankle and knee.

Mr. Russell reported that last week he had a MRI on the left knee, however, the physicians advised that they were not able to read it clearly because of the probable scar tissue. He stated the doctor said they could do an exploratory surgery, but did not know if this would be of any benefit to him or not. At the present time, he has no plans to undergo any further surgery on the hip, knee, ankle. Etc.

His treating physicians are:
- Dr. Randall Suarez Hip
- Dr. Barnaby Dedmond Leg

Both of the above doctors are located in the Lexington Orthopedic Center, West Columbia, SC.

- Dr. William Odom, Pain Management, 7921 Broad River Road, Irmo, SC 29063

Medications:
Hydrocodone AP 10-500 1 tab 4 times per day.
He cannot drive if he takes the pain medication.

Mr. Russell said that he was on blood thinner prior to the last surgery. The blood thinner has been discontinued.

Current Activities:
Mr. Russell generally arises approximately 7:30 AM depending on how he slept. He stated that the hip and leg pain interfere with his sleep.

He said he could be on his feet for one to one half-hours per day. He is able to drive a vehicle. He can drive for approximately two hours per day. He walks around his yard frequently to build up the muscles in his leg.

He is very limited in the amount of yard work he can do. He stated "most of the time I just sit in the house".

Education:
Mr. Russell has no other employment history. He is not computer literate. Mr. Russell completed the eighth grade. Mr. Russell is not engaged in any type of Rehab training. He was thinking about getting his GED.

Employment
He stated that his father was killed when he was in eighth grade. He had to quit school and go to work.

He stated that he has been working construction/house siding ever since that time. He has been self-employed. Mr. Russell had no other employment. He has no employees.

Mr. Russell advised that all of his work is of a physical nature. He stated that most of his work is siding new homes. He said that he has worked 13 years with a home building contractor, Mungo Homes, in Irmo, SC. His duties required him to stand on ladders, scaffolds, etc. He was constantly going up and down ladder steps.

Mr. Russell had full time work with Mungo Homes. He said he does not know if they will have work for him when or if he is able to return to work. His company is MCL Construction Co. LLC. Mrs. Russell stated that their Company is an S-Corporation.

He and his wife own the company. His wife is a CPA at Barb & Company. She works full time at Barb & Company.

Past Medical History:
Other than the injuries from the motor vehicle crash, Mr. Russell advised that he had no other impairments.

Military:
Mr. Russell has never served in the US Armed Forces.

Other Income:
Mr. Russell has no other disability or loss of time insurance. He recently applied for SSD and was denied benefits. He said that he is going to appeal the SSD decision.

Income:
Mrs. Russell advised his income would be approximately $4300.00 a month when he was working. Other than Mrs. Russell's income, they have no other household income.

Summary:
Mr. Russell has no idea when he can return to any type of work. He stated his job skills are very limited. He cannot type. His business is shut down.

He is hopeful that he will recover to the extent that he can return to some type of employment.

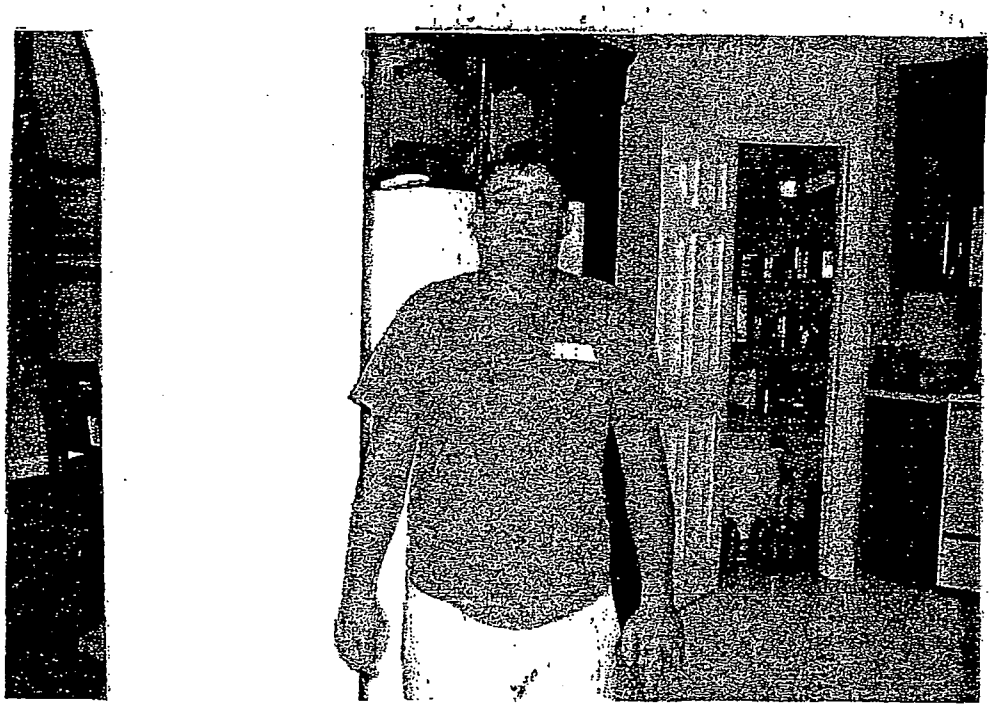
I secured his signature on a HIPPA Authorization and on a 4506 IRS Tax Release Form.

Mr. & Mrs. Russell inquired about the 4506 tax form. I told them that the Company needs to verify his income. Mrs. Russell advised that they file their taxes jointly. If the company has any questions about the tax forms, they are to call her.

I mentioned a final settlement to them. They said they would keep this in mind.

This concludes the handling of this assignment.

Enclosures:
Image of Mr. Miller
Image of Mr. Miller's residence
Image of Mr. Miller's residence/yard
HIPPA Authorization
IRS Form 4506 -Request for Copy of Tax Return

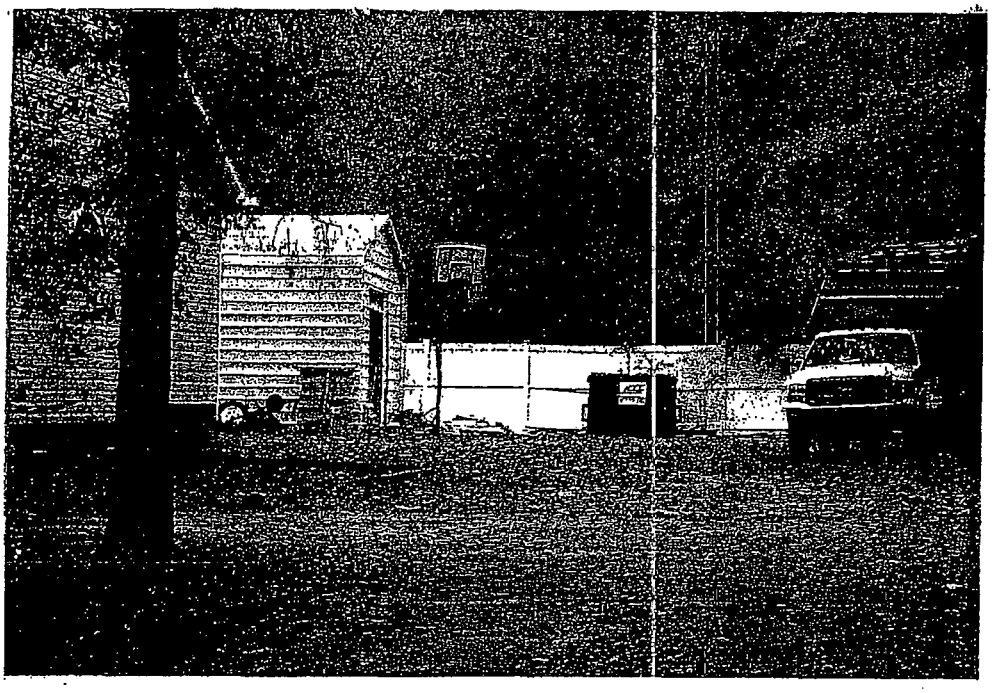


Michael Russell 11/18/2009 [redacted]9360



Michael Russell 11/18/2009 [redacted]9360 Residence

PLIC 0141



Michael Russell 11/18/2009 [redacted]9360 Residence/Yard

PLIC 0142

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	DATE AND TIME: December 31, 2009	
Policy Number and Policy Form: [redacted]9360		
Claimant Name: Mike Russell		
Caller Name: Insured		
Telephone Number: 803-513-0575	Incoming?	Outgoing? xxxx
Alternate Telephone Number:	Claim Number: 0809-00062	

NATURE OF CALL

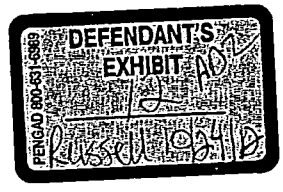
12/30/09 received a message from insured for status
12/31/09 Called insured back. Informed him that his claim is currently being reviewed due to the current medical records we received stating he was intoxicated at the time of the accident. His policy has an exclusion for intoxication. He said he was cleared of all of the charges of intoxication. I informed him that he never made us aware of it at the onset of his claim. At this time, it is being reviewed and I will keep him posted. He then said he was getting a lawyer and hung up.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

INformed insured when I called back on 1/6/10-see note

Signature: Ella Lee	Date: 12/31/09



0809-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 2 MIKE RUSSELL

IMPORTANT 8050
1. Print Clearly & answer all questions
2. If you need additional room to complete a question, attach a sheet of paper.
3. SIGN BOTTOM OF FORM

PLAINTIFF'S EXHIBIT 3 12-13-12 JK
PENCAD 800-631-6989

AUGUST 14, 2008

CLAIMANT'S NAME: Michael C. Russell Soc.Sec.Num: [redacted]
Date of Birth: [redacted] Home Phone: 803-955-0329 Work Phone: 813-513-0575

Are you receiving or applying for Worker's Compensation, Unemployment Compensation or other Disability benefits? YES ____ NO ✓ ? If YES, please provide the name and address of the company(ies) and the policy number(s).

Employer Name: MCB Construction LLC Employer Address: 1469 Dogwood Rd. West Columbia, SC 29172
Occupation: Owner of Company - Construction Monthly Gross Earnings: $ 4300
Job Duties: Owner, Vinyl Siding application
Were you working before you became disabled? YES ✓ NO ____ If NO, what were you doing? ____
If you are self-employed, is your business still operating? YES ✓ NO ____ If NO, when did it stop? ____
When did you first receive medical treatment? 6-18-08 Where? Lexington Medical Center
What is the name and address of the doctor treating you? Dr. Fogwinto 3 Medical Park Columbia, SC 29203
What is the name and address of any other doctors you have been referred to? ____
What is the name and address of your primary/family physician? Dr. Nagel 5535 Platt Springs Rd. Lexington SC 29073
If you were in the hospital, please give dates of confinement: Admitted 6-18-08 Discharged 7-1-08
Hospital: Lexington Medical Center Address: 3720 Sunset Blvd West Columbia SC 29169
Palmetto Richland 5 Richland Medical Park Columbia, SC 29203
(Include copy of hospital bill with this form)
Describe the sickness or injury Compound leg fracture, broken hip
If this is for a sickness condition, when did it first begin? ____
If this is an accident, when and where did it happen? Date: 6-18-08 Time: 9:30 PM Place: I-26 Exit 115
Describe how it happened. Motorcycle Accident
IF THIS IS A MOTOR VEHICLE ACCIDENT, PLEASE INCLUDE A COPY OF THE POLICE REPORT.
Have you ever had a similar condition in the past? YES ____ NO ✓ If YES, please give dates, a brief description and the name and address of the doctor who treated you. ____
IF EMPLOYED, did the condition above cause you to lose any time from work? YES ✓ NO ____ If YES, provide dates.
First Day not worked 6-19-08 What duties were you unable to do? all
When were you able to do SOME of your duties? Date: ____ ALL of your duties? Date: ____
IF RETIRED, A HOUSEWIFE, STUDENT OR UNEMPLOYED, did the above condition prevent you from doing your normal daily activities? YES ____ NO ____ If YES, provide dates. First Day unable to do activities ____
What activities were you unable to do? ____
When were you able to do SOME of your normal activities? ____
When were you able to do ALL of your normal activities? ____
Did this condition cause you to be confined? YES ____ NO ✓ If YES, provide dates. FROM ____ TO ____
Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Pennsylvania Life Insurance Company - PO Box 12355, Pensacola, FL 32591-2355
CLAIM AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE - any medical professional, medical care institution, consumer reporting agency insurance institution, insurance support organization, institution source, governmental agency including, but not limited to, the Social Security Administration and the Veterans Administration, the Medical Information Bureau, employer or any other individual or person to provide The Company, its officers, employees, agency or legal representative, and any insurance support organization and consumer reporting agency acting on The Company's behalf, with any and all medical records and personal information, requested about me or any of my minor children.
I UNDERSTAND that this Authorization will be used to obtain, information on the diagnosis, treatment, and prognosis with respect to any physical or mental condition as well as the use OT drugs or alcohol. I UNDERSTAND the information obtained by the use of this Authorization will be used by The Company or its agents, to determine eligibility for benefits under an existing policy. I KNOW that I or my legal representative may request to receive a copy of this Authorization. I AGREE that a photographic copy of the Authorization shall be as valid as the original. I UNDERSTAND that the duration of the Authorization is for. The term of coverage of the policy under which a claim for benefits has been submitted. If this Authorization is given in connection with a claim for disability or life insurance benefits, I UNDERSTAND that is valid for the duration of the claim.

Mike Russell 8-27-08
SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE 1052C

PLIC 0001

Attending Physician's Report

PATIENT'S NAME: Richard Russell DOB:

1. DIAGNOSIS: (Please provide ICD Code) Primary 808.0 Secondary 823.30

2. Describe any other disease or infirmity affecting the present condition.	
3. When did symptoms first appear or accident happen?	DATE: 6-18-08
4. If accident, please describe.	motorcycle accident
5. When did this patient first consult you for this condition?	DATE: 6-18-08 TIME ____ AM ____ PM
6. Has patient ever had same or similar conditions? If YES, please state when and describe	Yes ___ No ✓
7. Please provide the name(s) and address(es) of any other treating physician(s)	
8. Provide the CPT code and date of any surgeries performed.	CPT CODE: 27759 DATE: 6-24-08 CPT CODE: 27226 DATE: 6-24-08
9. a. If hospitalized, give name and address of hospital & admission & discharge dates.	Hospital: Palmetto Richland Memorial Address 5 Medical Pk. Dr. City Columbia State SC Admitted 6-20-08 Discharged 7-1-08
b. If confined to a nursing facility, give name and address of the facility and admission and discharge dates.	Nursing Facility ____ Address ____ City ____ State ____ Admitted ____ Discharged ____
10. Provide dates of treatment.	Office: 7/15/08, 8/11/08 Hospital: 6-20-08 - 7-01-08 Nursing Facility: ____
11. Is patient still under your care for this condition? If NO, give the date discharged from your care.	YES ✓ NO ____ DATE: ____
12. How long was (or will) the patient (be) continuously totally disabled (unable to perform substantially all of his/her occupational duties)?	FROM: WJ date TO: UNDETERMINED
13. How long was (or will) the patient (be) partially disabled (able to perform some but not all of his/her occupational duties)?	FROM: same as above TO: ____
14. If retired, housewife, student or other non-employed, please indicate a reasonable period of recovery.	No activities FROM ____ TO ____ Partial activities FROM ____ TO ____
15. Was house confinement necessary? If YES, give dates. (see definition of "confinement" below)	YES ____ NO ✓ FROM ____ TO ____

Confinement - Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

REMARKS

Name of Physician: (please print)
John Iaquinto

Address: 3 Med. Pk. Dr. Ste. 330
City: Columbia
State: SC Zip: 29203

Signature: [signature]
Date: 6/2/08 Tax ID # 582296052
Telephone #: 803-434-6958
Fax #: 803-434-8537

THANK YOU – Your time is appreciated
Pennsylvania Life Insurance Company P. O. Box 12355, Pensacola, FL 32591-2355

1052C

PLIC 0002

FedEx. US Airbill
Express

8626 5812 4

1 From This portion can be removed for Recipient's records.

8626 5812 4712

Date 9/3/08

Sender's Name NAME BARB Suzanne Purcell Phone 803 252-0606

Company BARB, SNYDER & CO

Address 1751 SAINT JULIAN PL

City COLUMBIA State SC ZIP 29204-2409

2 Your Internal Billing Reference

3 To

Recipient's Name Phone 800 275-7366

Company Pennsylvania Life Insurance Company

Recipient's Address 411 Baylen Street

Address

City Pensacola State FL ZIP 32501

0265132440

8626 5812 4712

RECIPIENT: PEEL HERE

fedex.com 1.800.GoFedEx 1.800.463.3339

THU - 04 SEP A2
STANDARD OVERNIGHT
32501
FL-US
BFM

FedEx 8626 5812 4712

XH PNSA

Dept 91300 9355/MB USCA

FedEx First Overnight — up to 150 lbs.

FedEx 2Day Freight — Packages over 150 lbs.

FedEx 3Day Freight

5 Packaging

FedEx Envelope* FedEx Pak* FedEx Box FedEx Tube Other

6 Special Handling

SATURDAY Delivery

HOLD Weekday at FedEx Location

HOLD Saturday at FedEx Location

Does this shipment contain dangerous goods?

No Yes Yes Dry Ice Cargo Aircraft Only

7 Payment Bill to:

Sender Recipient Third Party Credit Card Cash/Check

Total Packages Total Weight

8 Residential Delivery Signature Options

No Signature Required Direct Signature Indirect Signature

519

PENNSYLVANIA LIFE INSURANCE CO.

September 4, 2008

Mike Russell
1469 Dogwood Rd
W Columbia, SC 29172

RE: **Policy No: [redacted]9360**
Claim No: 0809-00062

Dear Mr. Russell

We have received your claim for benefits.

This has been referred to our claim department. You will hear from them just as soon as they have had an opportunity to review your file.

If you have any questions please contact us at 1-800-ASKPENN.

Sincerely,

Pennsylvania Life Insurance Company
Claims Department

PO Box 12355, Pensacola, Florida 32591-2355 • (Tel) 1-800-275-7366 (Fax) 1-850-432-6077

BANK OF AMERICA

PENNSYLVANIA LIFE INSURANCE COMPANY
ORLANDO, FLORIDA

06-278
611

09-22-08 00310325689

CLAIM NO: 0809-00062 POLICY: [redacted]9360

$8,125.00

EIGHT THOUSAND ONE HUNDRED TWENTY-FIVEDOLLARS AND 00 CENTS

MIKE RUSSELL

C

CO

[redacted]

PLEASE RETAIN THIS VOUCHER AS YOUR PAYMENT RECORD

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-22-08
DEPENDENT- CLAIM NO. 0809-00062 CHECK NO. BD310325689

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			600.00
1901	70	TOTAL DISABILITY	06-25-08	08-25-08	2MO	2000M	4,000.00
		TOTAL DISABILITY	06-25-08	08-25-08	2MO	500M	1,000.00
1904	00	SURGICAL BENEFIT	06-24-08	06-24-08			2,400.00
1946	00	AMBULANCE	06-18-08	06-18-08			50.00
		X-RAY	06-18-08	06-18-08			25.00
		EMERGENCY FIRST AID	06-18-08	06-18-08			50.00
						TOTAL THIS PAYMENT	8,125.00
						TOTAL PAID TO DATE	8,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0005

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

OCT 07 2008

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg and broken pelvis

2. What is the name and address of all physicians currently treating you?
   John Iaquinto - Premier Orthopedic Specialists
   3 Prineland Medical Park Dr. Suite 330
   Columbia, SC 29203

3. On what dates were you treated since completing your last report?
   office visit 9-22-08

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital _____
   Address _____
   Admitted: _____ Discharged _____

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed: _____

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, watching TV, completing physical therapy exercises, reading, completing puzzles etc.

DATE: 10-3-08 SIGNED: Mike Russell

ADDRESS: 1469 Dogwood Rd. West Columbia, SC 29172

C-3 R Rev. 4-97

PLIC 0006

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	S/P ① acetabulum fx, grade 3A open ② tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9/22/08
3a Next Appointment Date: 11.3.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? SAME	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NO	☐ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

[redacted]

Must be furnished under authority of the law

DATE: 10/2/08 SIGNED:

ADDRESS: 3 Medical Plz. Dr. Ste. 330 Columbia, SC 29203 TELEPHONE 803-434-6958

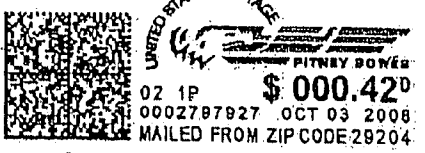
C-3 R

Rev. 3-96

PLIC 0007

ROA 1773

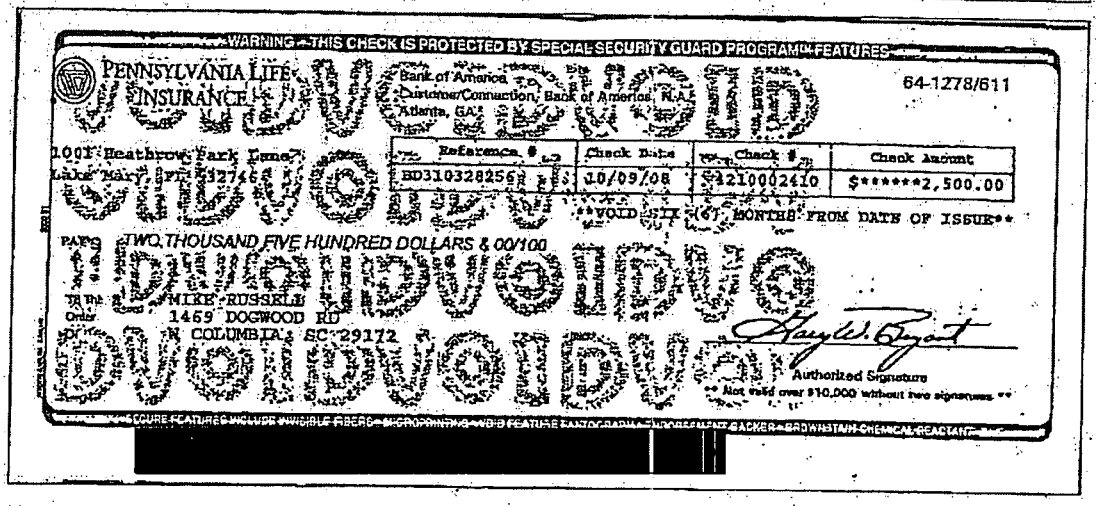
Russell

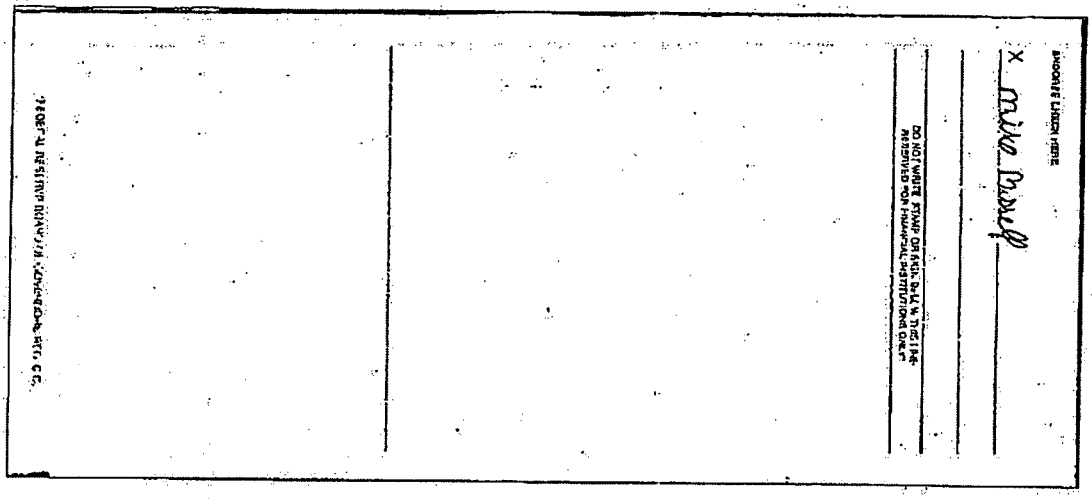


PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0008





Location	Acct #	Check #	Amount	Paid Date	Sequence	Customer Data
CD	[redacted]	4210002410	$2,500.00	10/20/2008	3194484695	

R/T Number	CD VoiID/CIMS Key	CD Label	Payee Name
6111278	08110340222101	08110340222101	

(w) 452-0002 (wife)

8052

PENNSYLVANIA LIFE INSURANCE COMPANY

3 MEDICAL PARK SUITE 330, P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

NOV 12 2008

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	~~Work~~ Cell	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   John Iaquinto - Premier Orthopedic Specialists 3 Richland Medical Park Dr. Suite 330 Columbia, SC 29203

3. On what dates were you treated since completing your last report?
   Office visit 11-3-08

4. Have you been confined to a hospital since completing your last report? no
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 11-3-08 SIGNED: Mike Russell

ADDRESS

C-2-P

Rev. 4-97

PLIC 0010

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	9p (L) acetabulum fx, grade 3A open (R) tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 9-22-08, 11-3-08
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? UNDETERMINED	
6. When did or will your patient be able to resume full work? UNDETERMINED	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) NOT SURE OF DATES	[X] YES [ ] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11/6/08 SIGNED:

ADDRESS: PREMIER ORTHOPEDIC SPECIALISTS
3 MEDICAL PARK, SUITE 330
COLUMBIA, SC 29203

TELEPHONE 803-434-6958

PLIC 0011

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 NOV 10 2006
MAILED FROM ZIP CODE 32204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

ROA 1777

PLIC 0012

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310331298	11/14/08	4210005455	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210005455
CHECK DATE 11/14/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-14-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310331298

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	13,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0013

350-0000

8890

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
DEC 17 2008
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080500062
cell	~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you?
John Iaquinto - Premier Orthopedic Specialists
3 Richland Medical Park Dr. Suite 330
Columbia, SC 29203

3. On what dates were you treated since completing your last report?
11-3-08

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 12908 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0014

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Acetabulum posterior wall fx/dislocation open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	undetermined as above
6. When did or will your patient be able to resume full work?	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 12/10/08 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803.434.6958
Columbia SC 29203

PLIC 0015

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 DEC 12 2008
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2055 B012

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 12-23-08
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310334348

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-08	11-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-08	11-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	15,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0017

01-28-09;03:48PM;

Cathy Claire

8090

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-080900062
	Cell			Policy No: [redacted]9360
	Work	803-513-0525		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg - hip

2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Ortho. 3 Richland Medical Park Dr. Suite 330 Cola, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7931 Broad River Rd. Irmo, SC 29063

3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

RECEIVED
JAN 28 2009
DISABILITY CLAIMS

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: SIGNED:

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0018

01-28-09;03:48PM;

PENNSYLVANIA LIFE INSURANCE COMPANY
P.O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Dacetabulum posterior wall fx/dislocation Open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11-3-08
3a. Next Appointment Date: 2-23-08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Undetermined
6. When did or will your patient be able to resume full work?	Undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/28/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr Ste. 330 TELEPHONE 803-434-6958
Columbia, SC 29203

C-3 R

Rev. 3-95

PLIC 0019

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
FEB 04 2009
PENSACOLA
RECEIVED
FEB 04 2009
PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-08090.00.52
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Iaquinto - Premier Orthopedic & Sports Medical Pain Dr. Suite 330 Cola, SC 29203
   Dr. William Odom - Advanced Pain Therapies 7981 Broad River Rd. Irmo, SC 29063
3. On what dates were you treated since completing your last report?
   11-3-08 Dr. Iaquinto
   12-17-08 Dr. Odom
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital _____
   Address _____
   Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing physical therapy exercises, reading, etc.

DATE: 1-28-09 SIGNED: Mike Russell

ADDRESS: _____

C-3.R Rev. 4-97

PLIC 0020

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 808.0, 823.30	Dacetabulum posterior wall fx/dislocate Open Tibia fx
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 11.3.08
3a Next Appointment Date: 2.23.08	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Undetermined
6. When did or will your patient be able to resume full work?	Undetermined
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined: (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 1/29/09 SIGNED:

ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803 434. 6958

Columbia, SC

PLIC 0021

Russell

COLUMBIA SC 292
29 JAN 2009 PM 1 T



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591#2355

ROA 1787

PLIC 0022

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310339762	02/11/09	4210013923	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210013923
CHECK DATE 02/11/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 02-11-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310339762

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-08	01-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-08	01-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		20,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0023

PENNSYLVANIA LIFE INSURANCE COMPANY

P.O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 13 2009
PENSACOLA

MIKE RUSSELL

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age: 36	Claim No: 02-001-001-080900062
	Cell			Policy No [redacted]9360
	~~Work~~	803-513-0575		

1. Describe the conditions causing your disability: motorcycle accident - broken leg + hip

RECEIVED
MAR 13 2009
PENSACOLA DISABILITY CLAIMS

2. What is the name and address of all physicians currently treating you? John Faquinto 3 Richland Medical Park Suite 330 Columbia, SC 29203
Dr. William Odom PO Box 1997 Elmo, SC 29063

3. On what dates were you treated since completing your last report?
Dr. Odom - Jan 19th, March
Dr. Faquinto Feb [illegible]

4. Have you been confined to a hospital since completing your last report? NO
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, Completing exercises, reading etc.

DATE: 3-10-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0024

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability. Degenerative Disease	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 3/2/09
3a Next Appointment Date: April 1, 2009	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
X 7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. # [redacted]

Must be furnished under authority of the law

DATE: 3/2/09 SIGNED: X [signature]

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-8585

PLIC 0025

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797827 MAR 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355

ROA 1791

PLIC 0026

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310342678	03/16/09	4210016833	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 42100168
CHECK DATE 03/16/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 03-16-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310342678

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-09	02-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-09	02-25-09	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	23,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0027

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

APR 08 2009

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	Cell			Policy No [redacted]9360
	~~Work~~	803-513-0575		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg and hip

2. What is the name and address of all physicians currently treating you?
   Dr. William Odom, PO Box 997 Irmo, SC 29063
   Dr. Kendall Suarez - Lexington Orthopedics, 146 A. Hospital Drive Suite 140, West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - April 1
   Dr. Suarez - march 17

4. Have you been confined to a hospital since completing your last report? no
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house, since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 4-6-09 SIGNED: Mike Russell

ADDRESS:

PLIC 0028

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 726.2	
2. Describe any other conditions contributing to present disability. Degenerative DZ	
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: April 1, 2009
3a. Next Appointment Date: April 29, 2009	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 4/1/09 SIGNED:

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-9585

PLIC 0029

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797827 APR 08 2009
MAILED FROM ZIP CODE 28204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1795

PLIC 0030

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310345383	04/10/09	4210019546	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210019546
CHECK DATE 04/10/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 04-10-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310345383

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-09	03-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	02-25-09	03-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		25,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0031

PENNSYLVANIA LIFE INSURANCE COMPANY 8090
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
RECEIVED
MAY 08 2009
MAY 08 2009
PENSACOLA
DISABILITY CLAIMS

Mike Russell

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 36	Claim No: 0809-00062
	Cell ~~Work~~	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   Motorcycle wreck - broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom
   PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington Orthopedic
   146 D. Hospital Dr. Suite 140
   West Columbia SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - April 09
   Dr. Suarez - April 21
   Dr. Dedmond - April 28

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting. Watching TV, completing exercises, reading, etc.

DATE: 4-29-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0032

PENNSYLVANIA LIFE INSURANCE COMPANY
EXECUTIVE OFFICES: P. O. Box 720, Buffalo, NY 14201-0720

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 715.93; 720.2	
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 4-29-09	Dates of treatment since last report: 4-29-09
3a Next Appointment Date: 5-28-09	Patient discharged on: not discharged
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital NO Address Admitted: _____ Discharged _____
5. When did or will your patient be able to resume some work or activity?	Unknown at present
6. When did or will your patient be able to resume full work?	Unknown at present
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

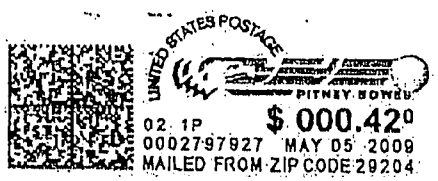
All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 4-29-09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC TELEPHONE 803-749-8585

PLIC 0033



Pennsylvania Life Insurance Co.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310348278	05/20/09	4210022422	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210022422
CHECK DATE 05/20/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 05-20-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310348278

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	03-25-09	04-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	03-25-09	04-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		28,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0035

8040

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

JUN 23 2009

RECEIVED

PENSACOLA JUN 24 2009

PENSACOLA DISABILITY CLAIMS

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age:	Claim No: 02-001-001-080900062
	Cell / ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo SC 29063	Dr. Juarez + Dr. Dedmond - Lexington Ortho pedics 146 D. Hospital Dr. Suite 110 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - May 08 Dr. Dedmond - May 8 (surgery) + May 20
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.) Out patient Surgery - Exchange Nailing ⓓ Tibia with Fibular Osteotomy	Hospital Lexington Medical Center Address West Columbia, SC 29169 Admitted: 5-8-09 Discharged 5-8-09
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 6-15-09 SIGNED: Mike Russell

ADDRESS: 1

C-3 R Rev. 4-97

PLIC 0036

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80	Closed Fracture Tibia
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 4/28/09 6/26/09 6/15/09	Dates of treatment since last report:
3a Next Appointment Date: 7-8-09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO	Hospital
(If "YES", give date of confinement and attach a copy of your hospital bill.)	Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unable to tell next eval 7-8-09	
6. When did or will your patient be able to resume full work? Unable to tell next re-eval 7-8-09	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 6/15/09 SIGNED:

ADDRESS: 1460 North Hospital Dr W. Col A S.C. TELEPHONE 803-936-7230

2/2/69

PLIC 0037

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT N	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
50809	DEDMOND MD	REPAIR TIBIA	MIKE	2,188.00		
		AMOUNT APPLIED TO DEDUCTIBLE: $619.29				
		Insurance Balance: 1,319.48		Patient Balance:		868.52
50809	DEDMOND MD	INCISION FIBULA	MIKE	947.00		
		Insurance Balance: 883.55		Patient Balance:		63.45

Statement Date: 05/21/09

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: [redacted]

Current	31-60 Days	61-90 Days	>90 Days	Total	Ins Pending	PATIENT BALANCE PAY THIS AMOUNT
3,135.00	0.00	0.00	0.00	3,135.00	2,203.03	931.97

REMIT INQUIRIES/PAYMENTS TO:
LEXINGTON ORTHOPAEDICS
146 N HOSPITAL DR SUITE 140
WEST COLUMBIA, SC 29169
803-936-8882

0564-72629 000562 000562 0000170000 92096502

NOTE: Charges and payments not appearing on this statement will appear on next month's statement. 92096S1

PLIC 0038

Bussell

UNITED STATES POSTAGE PITNEY BOWES
02 1P $ 000.44⁰
0002797927 JUN 22 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591X2355

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310353355	07/06/09	4210027524	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210027524
CHECK DATE 07/06/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 07-06-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310353355

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	04-25-09	05-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	04-25-09	05-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		30,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0040

0040

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
AUG 13 2009
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted] 9360

1. Describe the conditions causing your disability. motorcycle accident - broken leg + hip	
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom- June 25 Dr. Dedmond July 8
4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.) Out patient Surgery - exchange nailing ⓓ Tibia w/ Fibular Osteotomy	Hospital Lexington Medical Center Address West Columbia, SC 29169 Admitted: 5-8-09 Discharged 5-8-09
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 7-29-09 SIGNED: Mike Russell

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0041

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80 808.0	closed fracture unspecified tibia Acetabular Fracture
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 5/8/09	Dates of treatment since last report:
3a Next Appointment Date: 8/26/09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unknown	
6. When did or will your patient be able to resume full work? Unknown	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Pt underwent surgery on 5/8/09 for a left tibial nonunion

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/09 SIGNED:

ADDRESS: 146 N. Hospital Dr. W. Columbia, SC 29169 TELEPHONE 803-936-7230

PLIC 0042

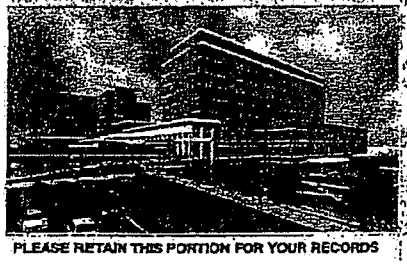
YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs. We have received your payment. Please pay the balance in full or contact Customer Service for any questions regarding this bill.

10237-P555

SUMMARY OF CHARGES

250 PHARMACY GENERAL	62.00
258 PHARMACY IV SOLUTIONS	130.00
259 PHARMACY OTHER	16.25
270 MIS SUPPLY GENERAL	618.00
272 MIS SUPPLY STERILE SUPPLY	5866.11
278 MIS OTHER IMPLANTS	27716.50
300 LABORATORY GENERAL	13.00
302 LABORATORY IMMUNOLOGY	90.00
305 LAB HEMATOLOGY	226.00
306 LAB BACTERIOLOGY/MICROBIO	336.00
312 LAB PATHOLOGY/HISTOLOGY	22.00
320 RADIOLOGY DIAG GENERAL	525.00
350 DR SVCS GENERAL	502.00
370 ANESTHESIA GENERAL	1284.00
636 DRUG SPEC ID DETAIL CODING	34.00
710 RECOVERY ROOM GENERAL	1210.00
964 PROF FEES ANES METH STUDIES	3600.00
Billed charges to date:	51303.96



PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

PAGE: 1 of 1

0101

MICHAEL C RUSSELL

[redacted]

INSURANCE INFORMATION

BLUE CHOICE/COMPANION ZCL30241197

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2300 OR (877) 885-9575, MONDAY-FRIDAY, 8:30 AM TO 5:30 PM. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	06/25/09
Patient Name:	MICHAEL C RUSSELL
Date of Service:	05/08/09
Account Number:	[redacted]
Total Charges:	51303.96
Insurance Payments Received:	-30414.91
Adjustments to Insurance:	-18443.63
Patient Payments Received:	-35.00
This is your balance:	2483.42

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.

CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
07/10/2009	06/25/09	[redacted]

AMOUNT DUE	SHOW AMOUNT PAID HERE
2483.42	$

651741E

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*TON0J1BBU000149

PLIC 0043

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 AUG 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1809

PLIC 0044

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC, 29 29172

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-08-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0045

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
SEP 28 2009
PENSACOLA

MIKE RUSSELL

Dependent Name

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~			Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg and hip

2. What is the name and address of all physicians currently treating you?
Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Desmond - Lexington Orthopedic 140 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - Aug. 25
Dr. Desmond + Suarez Aug. 26

4. Have you been confined to a hospital since completing your last report? no
(If "YES", give date of confinement and attach a copy of your hospital bill.)
Hospital
Address
Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

RECEIVED
SEP 28 2009
PENSACOLA DISABILITY CLAIMS

7. When do you expect to begin working at all of your duties?
unknown

8. Have you been confined to the house since completing your last report?
(See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc.

DATE: 9-23-09 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0046

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80, 823.81 996.4	closed fracture of tibia closed fracture of fibula mechanical compl. of internal orthopaedic device
2. Describe any other conditions contributing to present disability: See above	
3. Describe dates of treatment since last report and indicate if patient is still under your care 7/8/09 8/26/09 yes	Dates of treatment since last report: 8/26/09, 7/8/09 &
3a Next Appointment Date: 9/29- Dr. Suarez 10/26/09- Dr. Dedmond	Patient discharged on: n/a
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? unable to determine - re-eval on 10/26 surgery on 10/5/09 w/Dr. Suarez for hip	with Dr. Dedmond- for leg
6. When did or will your patient be able to resume full work? unable to determine	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

patient being treated by Dr. Barnaby Dedmond for his left tibia/fibula fracture and will be evaluated and treated by Dr. Randall Suarez for his hip.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/18/09 SIGNED: B Dedmond

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive
Suite 140
West Columbia, SC 29169

TELEPHONE 803-936-7230

C-3 R

Rev. 3-96

PLIC 0047

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 SEP 24 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1813

PLIC 0048

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 10-09-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310361735

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0049

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

RECEIVED
OCT 27 2009
PENSACOLA DISABILITY CLAIMS

MAIL CENTER
OCT 27 2009
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0525		Policy No [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 W. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom- Aug. 25
Dr. Dedmond Aug. 26
Dr. Suarez Sept. 09

4. Have you been confined to a hospital since completing your last report? Yes
(If "YES", give date of confinement and attach a copy of your hospital bill.) have not received bill yet
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 10-5-09 Discharged 10-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☑ YES, I have been confined to the house since completing my last report.
☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 10-21-09 SIGNED: Mike Russell

ADDRESS: [redacted]

C-3 R

Rev. 4-97

PLIC 0050

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	733.42
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care 3a Next Appointment Date:	Dates of treatment since last report: 10-26-09 Dr. Dellinger 9/29/09 - Dr. Suarez 10/5/09 - Dr. Suarez (Surgery) 10-29-09 Suarez Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: Lexington Medical Center Address: 2720 Sunset Blvd Admitted: 10-5-09 Discharged 10-8-09
5. When did or will your patient be able to resume some work or activity?	Approx: 1-5-10
6. When did or will your patient be able to resume full work?	Approx 1-5-10
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[ ] YES [X] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

Lexington Orthopaedics
146 N. Hospital Drive, Ste. 140
West Columbia, SC 29169
(803) 936-7230

DATE: 10-20-09 SIGNED: [signature]

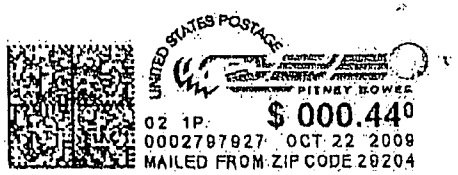
ADDRESS: TELEPHONE

C-3 R Rev. 3-96

PLIC 0051

ROA 1817

Russell



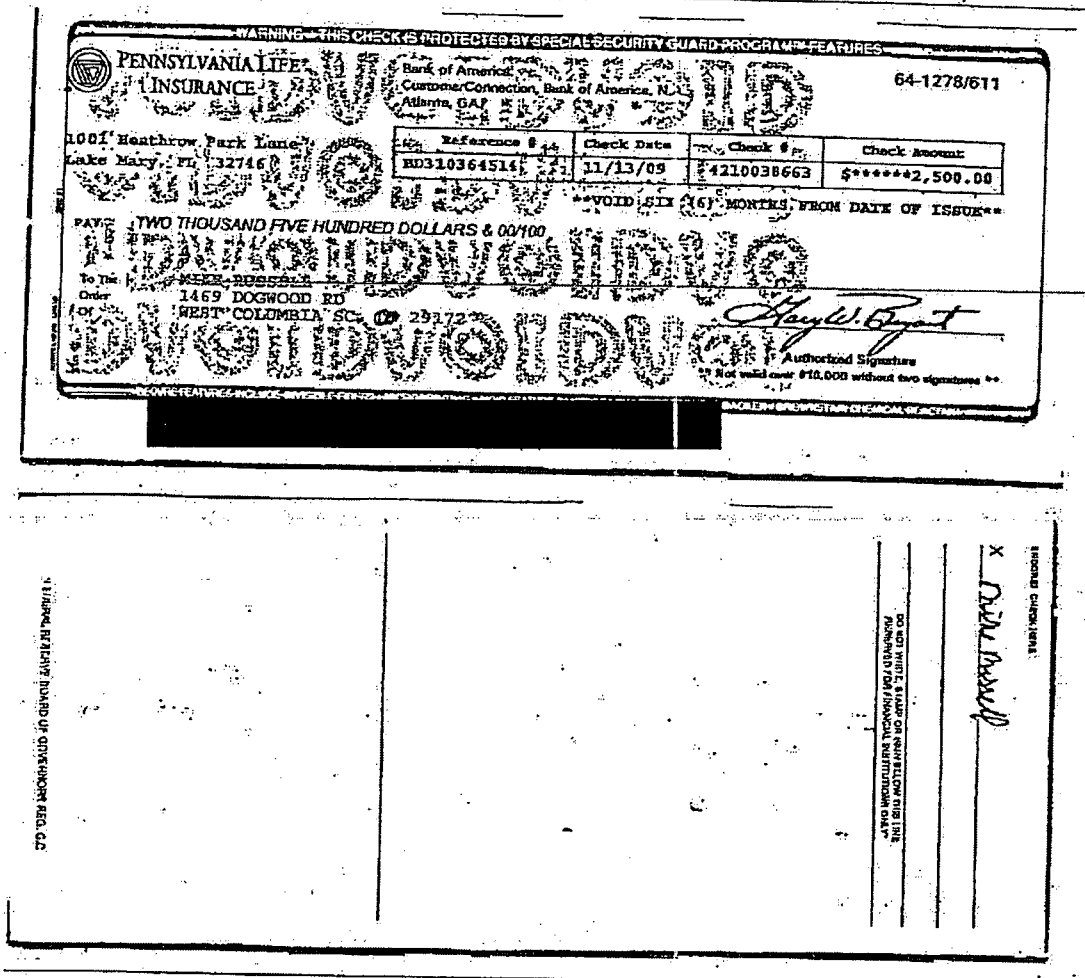
PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0052

Document type : Disbursement Check

06/03/2010 12:10 PM



Tag	Note	Item Date	Sequence Number	Account Number
Routing Number	Amount	Serial Number	Image Indicator	Sorry Indicator
Customer Data	Payee Name	Volume ID	Account Name	Issue Date
No	No	11/20/2009	2394675855	[redacted]
6111278	2500.00	4210038663	1	0
		091201000771101		

Bank of America

Page 1/1

PLIC 0053

ROA 1818

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 08 2009

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~			Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg + hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Dedmond- Lexington Ortho. 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom- Oct 26
   Dr. Dedmond Oct. 26
   Dr. Suarez Oct. 29, Nov. 10

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:

7. When do you expect to begin working at all of your duties?
   unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☑ YES, I have been confined to the house since completing my last report.
   ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 12-2-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0054

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Tib/fib fx - rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09, 10-29-09, 11-10-09
3a Next Appointment Date:	Patient discharged on: No
4. Has the patient been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11-30-09 SIGNED: Randall S. Stubbs, M.D.

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste 140
West Columbia, SC 29169
(803) 936-7[illegible]

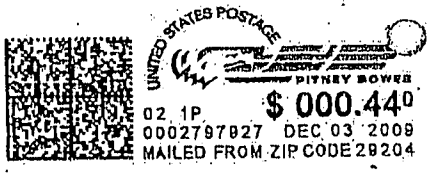
TELEPHONE

C-3 R

Rev. 3-96

PLIC 0055

Russell



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1821

PLIC 0056

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 01-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER		BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
		TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
						TOTAL THIS PAYMENT	5,000.00
						TOTAL PAID TO DATE	45,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0057

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER JAN 28 2010 PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	955-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~ Cell	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg and hip
2. What is the name and address of all physicians currently treating you?
   Dr. Odom, P.O. Box 1997, Irmo, SC 29063
   Dr. Suarez + Dr. Redmond - Lexington Orthopedics, 196 N. Hospital Dr. Suite 140, West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   Dr. Odom - 1-18-10
   Dr. Suarez - 12-17-09
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital: _____
   Address: _____
   Admitted: _____ Discharged: _____
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed: _____
7. When do you expect to begin working at all of your duties?
   Unknown
8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since: _____

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 1-25-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0058

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Hip / Fib rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 12-17-09
3a Next Appointment Date: 1-28-10	Patient discharged on: —
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address: Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

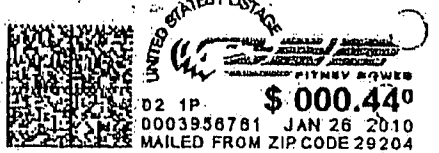
Must be furnished under authority of the law

DATE: 1/20/10 SIGNED: Randall S Stuart, M.D.

ADDRESS: Lexington Orthopedics 146 N. Hospital Drive, Ste.140 West Columbia, SC 29169 (803) 936-7230 TELEPHONE

C-3 R Rev. 3-96

PLIC 0059



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0060

ROA 1825

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 02-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0061

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2010
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0389	Age: 37	Claim No: 02-091-001-0809000063
	Cell			Policy No: [redacted]9360
	~~Work~~	803-513-0575		

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip
2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr - Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   Dr. Odom - 1-18-10
   Dr. Suarez - 2-25-10
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
7. When do you expect to begin working at all of your duties?
   Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 3-1-10 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0062

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) total h.p. 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) hip/Lb rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 1/25/10, 2/25/10
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2-25-10 SIGNED: Randall S. Bragg, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

TELEPHONE

C-3 R

Rev. 3-96

PLIC 0063

ROA 1829

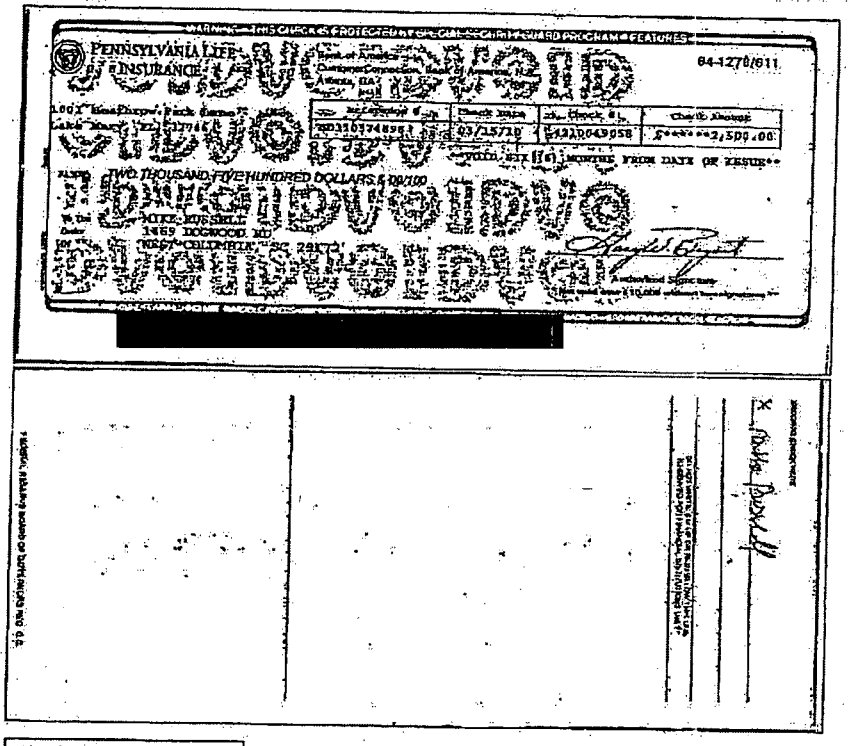
PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0064

Bank of America Higher Standards

Bank of America Direct



Check Info	
Account:	[redacted]
Amount:	2,500.00
Check #:	4210049058
Posted Date:	03/24/2010

Bank of America, N.A. Member FDIC.
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PLIC 0065

ROA 1830

SOCIAL SERVICES SYSTEM
A & H CLAIM STATUS SHEET

REQ'S

PAGE 01

POLICYHOLDER CLAIM INFORMATION		
EMPLOYER: MCR Construction	AGE: 35	DATE OF BIRTH: [redacted]
OCCUPATION: owner of Construction Co	WORK TELEPHONE: cell#	
	HOME TELEPHONE:	

MIKE RUSSELL

[redacted] 29172

DEPENDENT CLAIM INFORMATION		
NAME	AGE	DATE OF BIRTH
RELATIONSHIP	OCCUPATION	

CLAIMANT	CLAIM NUMBER	ADJUSTOR	DATE OPENED	DATE INCURRED
01	0809-00062	4069	09/04/08	06/18/08

CONDITION	01	DESCRIPTION: 808.0 - Closed fracture of acetabulum (Hip)
CAUSE	20	823.30 - Fracture of upper end of tibia + fibula Closed (Shin Bone / Calf Bone)

IMPAIRMENTS: NEW Diagnosis 733.42 Aseptic necrosis of medial femoral Condyle (10/20/08)

Policy Number				
[redacted] 9360 001	001 PENNSYLVANIA LIFE			
Prem. Paid To	Total Premium	St/Sale	Agent	Office
09/19/08	22120.50	00	171111	0091477
Application Date	Issue Date	Mode	Last Lapse	Last Reinstate
	11/19/99	01		

INCREASE FORM ON POLICY

595 OPELV

COVERAGE			EFFECTIVE
1903 00GO			11/19/99
20 AD	25000/0		25000.00
R 1 1904 X00GO	ACC	$50 ded.	11/19/99
50 SURGERY	1000/*	MAXIMUM	1000.00
54 SURGERY-OUT	500/0		500.00
R 2 1901 70GO	ACC		11/19/99
12 TD	2000/M	ELM 7	9999999.99
40 HOSPITAL	2000/M		9999999.99
R 3 301 00GG			11/19/99
R 4 1901 ✓70GO	ACC		07/19/02
12 TD	500/M	ELM 7	9999999.99
40 HOSPITAL	500/M		9999999.99
R 5 1904 00GO	ACC	$500 ded 1900	07/19/02
50 SURGERY	4000/*	MAXIMUM	4000.00
54 SURGERY-OUT	2000/0		2000.00
R 6 1946 X00GO			07/19/02
44 HOSP ICU	25/0	X	25.00
53 CAST/CRUTCH	25/0	✓	25.00
60 AMBULANCE	50/0	1000	50.00
61 X-RAY	25/0	✓	25.00
62 FIRST AID	50/0	✓	50.00
R 7 ~~1903 0000~~			07/19/02
~~20 AD~~	~~75000/0~~		75000.00
R 8 301 00GG			07/19/02
~~R 9 1911 X030B~~	~~Sickness~~		08/19/02
~~12 TD~~	~~2500/M~~	ELM 30	60000.00

COVERAGES CONTINUE NEXT PAGE

Waiver of Prem. Eligible: NONE

4000 ÷ 500 = 8 x 125 = 1000

2x covered for 2 years

Same as Main Parts

[redacted]

No other Policy

Hospital 6/20/08 - 07/01/08

PRIOR CLAIMS

Claim Number	Incurred Date	Total Paid	Status	Nature Code	Date Closed
NO PRIOR CLAIMS FOUND					

surgery 27759 - (6/24/08) - Treatment of tibia fracture

27226 - (6/24/08 - open treatment of posterior or Anterior acetabular wall fracture with internal fixation.

USE LEG for Cpt code for surgery

↳ Pay 1/2 for Hip Surgery

Per Cpt Schedule + Policy: 150 + 75 = 225/500

IM 450 (1-83)

SX 5/8/09 - Repair of non-union fx iliac, ilium, or other acetabulum (27227

PLIC 0088

SPECIAL SERVICES SYSTEM

A & H CLAIM STATUS SHEET

REQS

POLICYHOLDER CLAIM INFORMATION		
EMPLOYER	AGE 35	DATE OF BIRTH [redacted]
OCCUPATION	WORK TELEPHONE	
	HOME TELEPHONE	

MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA SC 29172

DEPENDENT CLAIM INFORMATION		
NAME	AGE	DATE OF BIRTH
RELATIONSHIP	OCCUPATION	

CLAIMANT	CLAIM NUMBER:	DATE OPENED	DATE INCURRED
01	0809-00062	09/04/08	06/18/08

ADJUSTOR: 4069

CONDITION	DESCRIPTION
CAUSE	

IMPAIRMENTS:

Policy Number [redacted]9360

Prem. Paid To	Total Premium	St/Sale	Agent	Office
Application Date	Issue Date	Mode	Last Lapse	Last Reinstate

COVERAGE		EFFECTIVE
40 ~~HOSPITAL~~	2500/M	9999999.99
R10 ~~1914~~ 000G	SICK	08/19/02
50 ~~SURGERY~~	5000/*MAXIMUM	5000.00
54 ~~SURGERY-OUT~~	2500/O	2500.00
R11 301 00GG -		08/19/02

Waiver of Prem. Eligible:

PRIOR CLAIMS

Claim Number	Incurred Date	Total Paid	Status	Nature Code	Date Closed

FORM 450 (1-83)

PLIC 0089

Claim History Log

Date: February 12, 2009 Claim No.: 0809-00062
Insured: Mike Russell Age: 36 Sex: Male Occupation: Own Construction
Policy No: [redacted]9360 Date of Onset: 06/18/08
Initial Diagnosis: Closed fx of hip, fx of upper shin bone and calf bone
Contributing Factors: Motorcycle Accident Impairment Rider: 1904, 1901, 1946

Date (Chronological)	**Summary of DX, Tests, Consults SX. RX. TX, Complications, ect.**
06/18/08	Motorcycel accident happen around 9:30 pm on 06/18/08. He was admitted in Lexington Hospital on 06/19/08 (early that morning) but they were not equipped to handle the surgery so they sent him to Richland Hospital to have it done. He then stayed at the hospital from 06/20/08-07/01/08. His surgery was performed on 06/24/08. They placed a metal plate in his hip and medal rods in his leg. He is currently on crutches and a walking boot. The doctor stated he could use 20% of his body weight each month. No other surgeries scheduled. He owns his company and is an on site worker.
10/27/08	Per insured. He has a compound fracture that will not heal and the muscle in his hip is still sore. He takes physical therapy twice a week. Insured is not satisfied with his current doctor because he is not progressing like he should. Wants to seek a second opinion. Doctor did not give him a time frame as to when he could return to work.
01/27/09	Per insured wife, the current orhto doctor refuses to fill out the scf for them. She wanted to know if it can be filled out by his pain management doctor instead and was given approval to do so after I spoke to doctors office and confirmed it through his assistant Angie

Pennsylvania Life Insurance Comp
www.pennlife.com

MAIL CENTER
8000

NOV 25 2008
PENSACOLA

HIPAA Authorization Addendum

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB Group, Inc., employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Pennsylvania Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's " Notice of Privacy Practices" is available upon request.

RECEIVED
NOV 26 2008
PENNSYLVANIA LIFE

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of revocation. This authorization may be revoked upon submission of a written notice to The Company's Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke is also subject to the rights of The Company under any law granting The Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Patient's Name:

First	Middle	Last
Mike		Russell

Other Names Used:

Date of Birth: [redacted]/72

Social Security Number: [redacted]

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18)
Mike Russell

Date: 11-17-08

Signature of Spouse:
(If applying for coverage)

Date:

Signature of Authorized Representative:

Relationship:

Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AA-0403

PLIC 0091

MAIL CENTER
8890
NOV 25 2008
PENSACOLA

Pennsylvania Life Insurance Company
www.pennlife.com

HIPAA Authorization Addendum

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB Group, Inc., employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Pennsylvania Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's " Notice of Privacy Practices" is available upon request.

RECEIVED
NOV 26 2008

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Patient's Name:

First	Middle	Last
Mike		Russell

Other Names Used:

Date of Birth: [redacted]72

Social Security Number: [redacted]

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18)

Date: 11-17-08

Signature of Spouse:
(If applying for coverage)

Date:

Signature of Authorized Representative:

Relationship:

Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AA-0403

62D2 [redacted]9360; .AS-OF 09/10/08;. RUSSELL, MIKE M-27 [redacted]

AGE	RTE	IS	CEASE	FACE/UN	ANNUAL
(01)--1903ADB - D10-05000-9-C-K19-03-					
U27		11-19-99	11-72	25,000	23.75
AE=000 SE=000 AB=LIFE SB=0D					
PF1	100		11-72	1.000	15.00
(02)3-1904SURG - C10-05000-9-C-G19-04-					
U27		11-19-99	11-72	1,000	11.50
AE=000 SE=000 AB=LIFE SB=0D					
(03)3-1901DIS - A10-05000-9-C-A19-01-					
U27		11-19-99	07-72	2,000	734.00
AE=007 SE=000 AB=LIFE SB=0D					
(04)3-301-1900RP - H10-05000-9-C-Q30-1 -					
U27		11-19-99	11-19	100	258.80
AE=000 SE=000 AB=LIFE SB=LIFE					
(05)3-1901DIS - A10-05000-9-C-A19-01-					
U30		07-19-02	07-72	500	183.50

CK621 PRESS ENTER TO CONTINUE DISPLAY

* NOTES

SUS-STAT-ENT-ASN/O-MEC-PAR-RE-NFO--TRN			
NO 22 GC NO /0		N 1- 0	NONE NO
PLAN- 1903ADB		LAST PREM	CASH
PAC-M	260.02	PAID TO	09/19/08
FACE	25000.00	BILLED TO	09/19/08
CV	.00	ISSUE	11/19/99
OTHER	** NONE **	PAY UP	11/19/72
LOAN	.00	LAST BILL	08/19/08
PYOFF	.00	LAST ACCT	08/19/08
SUSP	.00	LAST OTHR	08/26/02

09/10/08 PDCAJ
CICSP10 00

PLIC 0093

62D2 [redacted]9360; .AS-OF 09/10/08;. RUSSELL, MIKE M-27 [redacted]

* NOTES

AGE RTE IS CEASE FACE/UN ANNUAL	SUS-STAT-ENT-ASN/O-MEC-PAR-RE-NFO--TRN			
	NO 22 GC NO /0	N 1- 0 NONE NO		
(06)3-1904SURG - C10-05000-9-C-G19-04-	PLAN- 1903ADB	LAST PREM CASH		
U30 07-19-02 07-72 4,000 50.80	PAC-M 260.02	PAID TO 09/19/08		
AE=000 SE=000 AB=LIFE SB=0D	FACE 25000.00	BILLED TO 09/19/08		
	CV .00	ISSUE 11/19/99		
(07)3-1946EMERG - H10-05000-9-C-Q19-46-	OTHER ** NONE **	PAY UP 11/19/72		
U30 07-19-02 07-72 50 39.50	LOAN .00	LAST BILL 08/19/08		
AE=000 SE=000 AB=LIFE SB=0D	PYOFF .00	LAST ACCT 08/19/08		
	SUSP .00	LAST OTHR 08/26/02		
(08)3-1903ADB - D10-05000-9-C-K19-03-				
U30 07-19-02 07-72 75,000 71.25				
AE=000 SE=000 AB=LIFE SB=0D				
(09)3-301-1900RP - H10-05000-9-C-Q30-1 -				
U30 07-19-02 11-19 100 113.87				
AE=000 SE=000 AB=LIFE SB=LIFE				
(10)3-1911DIS - A10-05000-9-C-B19-11-				
U30 08-19-02 07-72 2,500 770.00				
AE=000 SE=30 AB=0D SB=2YR				

09/10/08 PDCAJ
CICSP10 00

CK621 PRESS ENTER TO CONTINUE DISPLAY

PLIC 0094

62D2 [redacted]9360; AS-OF 09/10/08; RUSSELL, MIKE M-27 [redacted]

* NOTES

AGE	RTE	IS	CEASE	FACE/UN	ANNUAL			
PP2	100		07-72	1.000	35.00			
(11)3-1914SURG - C10-05000-9-C-H19-14-								
U30	08-19-02		08-72	5,000	238.00			
AE=000 SE=000 AB=0D SB=LIFE								
(12)3-301-1900RP - H10-05000-9-C-Q30-1 -								
U30	08-19-02		11-19	100	344.19			
AE=000 SE=000 AB=LIFE SB=LIFE								

SUS-STAT-ENT-ASN/O-MEC-PAR-RE-NFO--TRN			
NO 22 GC NO /0	N 1- 0	NONE NO	
PLAN- 1903ADB		LAST PREM	CASH
PAC-M	260.02	PAID TO	09/19/08
FACE	25000.00	BILLED TO	09/19/08
CV	.00	ISSUE	11/19/99
OTHER	** NONE **	PAY UP	11/19/72
LOAN	.00	LAST BILL	08/19/08
PYOFF	.00	LAST ACCT	08/19/08
SUSP	.00	LAST OTHR	08/26/02

09/10/08 PDCAJ

CK620 DISPLAY COMPLETE CICSP10 00

PLIC 0095

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

JUL 3 0 2002

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

APPLICATION FOR INSURANCE

DATE M M D D Y Y Y Y: 07 05 2002

MAIL PREMIUM NOTICES: ☐ BUSINESS ☑ RESIDENCE ☑ INCREASE

POLICY NO [redacted] 9360

POLICYHOLDER ☐ NEW ☑ CURRENT

INSURED NAME

LAST: Russell SUFFIX: FIRST: Mike MI: C SOCIAL SECURITY NUMBER: [redacted]

ADDRESS (Street/Rural Route): ADDRESS (Line 2):

CITY: STATE: ZIP CODE: COUNTY:

AREA CODE/ TELEPHONE: 8039550329 BEST TIME/ DAY TO CALL: eve AGE: 29 BIRTHDATE (MMDDYYYY): [redacted] STATE OF BIRTH: IC SEX: M

HEIGHT (Ft. In.): 5 09 WEIGHT: 160 WEIGHT CHANGE LAST 12 MONTHS: NONE ☑ GAIN ☐ LOSS ☐ NUMBER OF LBS: REASON:

OCCUPATION: Siding CLASS: 2A Average Monthly Salaried Earnings (Gross): Average Monthly Self-Employed Earnings After Expenses: 7500 EXACT DUTIES: Install attic siding

EMPLOYER: Self AREA CODE/ TELEPHONE: HIRE DATE:

EMPLOYER ADDRESS (Street/ Rural Route): Same CITY: STATE: ZIP CODE:

BENEFICIARY NAME: Susanne Russell RELATIONSHIP: wife

SPOUSE TO BE INSURED

LAST: SUFFIX: FIRST: MI: SOCIAL SECURITY NUMBER:

AGE: BIRTHDATE (MMDDYYYY): STATE OF BIRTH: SEX: Height (Ft. In.): WEIGHT: Weight Change Last 12 Months: NONE ☐ GAIN ☐ LOSS ☐ Number of Lbs: REASON:

OCCUPATION: CLASS: Average Monthly Salaried Earnings (Gross): Average Monthly Self-Employed Earnings After Expenses: EXACT DUTIES:

EMPLOYER: AREA CODE/ TELEPHONE: HIRE DATE:

EMPLOYER ADDRESS: CITY: STATE: ZIP CODE:

BENEFICIARY NAME: RELATIONSHIP:

CHILDREN TO BE INSURED UNDER THIS POLICY

LAST NAME	FIRST NAME	MI	SEX	AGE	BIRTHDATE (MMDDYYYY)

AUG 0 2 2002 BUSINESS DEPT.

Please check one of the following: APP ☐ ORIGINAL 1900 ☑

I HEREBY APPLY FOR THE FOLLOWING COVERAGE FOR THE FAMILY MEMBERS NAMED ABOVE:

Form Series: Monthly ADB Riders - Not Available To Children

	PRIMARY INSURED MONTHLY AMT	PRIMARY INSURED BENEFIT PERIOD	SPOUSE MONTHLY AMT	SPOUSE BENEFIT PERIOD
ACCIDENTAL DEATH BENEFIT (1933)	$	YEARS	$	YEARS
MOTOR VEHICLE ADB (1934)	$	YEARS	$	YEARS
COMMON CARRIER ADB (1935)	$	YEARS	$	YEARS
PREMIUM	$		$	

PAYMENT MODE:
ANNUAL ☐
SEMIANNUAL ☐
PAC ☑
PRD ☐

ADB MODE PREMIUM: $ ~~7.58~~

OFFICE CODE	AGENT	NAME	%	OFFICE CODE	SUBAGENT CODE	NAME	%	AMOUNT PAID
044425	173416	Rei						249.69

PA 1900 SC Rev. 3 6.01

PLIC 0096

FORM SERIES 1900 - ACCIDENT AND SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 ☐ 1941 ☐ Benefit / Elimination — Insured / Spouse	per month	per month	
OFF-JOB DISABILITY ACCIDENT* (1945) Benefit / Elimination — Insured / Spouse	per month	per month	
HOSPITAL ACCIDENT 1902 ☐ 1942 ☐	per day	per day	per day
SURGICAL ACCIDENT 1904 ☐ 1944 ☐	max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946)	max	max	
ACCIDENT CONVALESCENT (1947) Multiple of Hospital Days: ☐	per day	per day	per day
ACCIDENT INTENSIVE CARE (1948)	per day	per day	per day
PERSONAL CARE BENEFITS* 1949 ☐ 1973 ☐	per day	per day	
ACCIDENTAL DEATH 1903 ☐ 1943 ☐	lump sum	lump sum	lump sum
DISABILITY SICKNESS* (1911) Benefit: Insured 2 / Spouse; Elimination: Insured 30 / Spouse	2500 per month	per month	
HOSPITAL SICKNESS (1912)	per day	per day	per day
SURGICAL SICKNESS (1914)	5000 max	max	max
SICKNESS CONVALESCENT (1957) Multiple of Hospital Days: ☐	per day	per day	per day
SICKNESS INTENSIVE CARE (1964)	per day	per day	per day
OTHER RIDER:			
OTHER RIDER:			

ACCIDENT/SICKNESS PREMIUM (excl. Monthly ADB premium from front) $ | $ | $

INFLATION PROTECTION ☐ YES (Does NOT apply to Monthly ADB Riders included in the policy)

A/S PREMIUM WITH INFLATION $ | $ | $

PREMIUM INCL. MONTHLY ADB FROM FRONT $ | $

INCREMENTAL COST $

SUBTOTAL $ | $ | $

WAIVER OF PREMIUM ☐ YES $

(Waiver of Premium will apply to any Monthly ADB Riders included)

TOTAL PREMIUM - ALL COVERED INSUREDS $ (inc ROP)

Includes Inflation, Waiver and any Monthly ADB Premium

TOTAL MODE PREMIUM: $ (Includes ADB premium from front)

*Disability Income, Emergency Treatment and Personal Care benefits NOT available to children

PLIC 0097

ROA 1840

COMPLETE FOR ALL COVERAGES BELOW

	YES	NO
1. Do you or your spouse have any disability or accident and sickness insurance currently in force, or do you or your spouse have an application for insurance pending?	☑	☐
2. Does any Family Member to be insured have, or within the past five (5) years has any Family Member had, other coverage with Pennsylvania Life Insurance Company?	☑	☐
3. Does any Family Member to be insured intend to replace any existing insurance with the insurance now applied for? If yes, Name of Company _____ Policy No. _____	☐	☑
4. Are you or your spouse currently disabled?	☐	☑
5. Have you or your spouse, within the past five (5) years, made claim to an insurance company or compensation board or government agency for injury or sickness?	☐	☑
6. Has any Family Member to be insured had any application for life or disability income insurance declined, postponed, modified, cancelled or had renewal refused within the past five (5) years?	☐	☑
7. Have you or your spouse lost 10 or more days from work during the last 12 months?	☐	☑
8. Does any Family Member to be insured have a current Medicaid Eligibility Card?	☐	☑

GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 8: (Attach additional sheets if necessary.)

Ques. No.	Name of Person	Company	Type (or Policy No.)	Details of medical condition. If showing existing insurance, give benefit amounts, benefit and elimination periods, if applicable.
1-2	Mike Russell	Penn Life	[redacted]9360	

	YES	NO
9. Have you or any of the Family Members applying for coverage had, or been treated for any of the following within the past five (5) years:		
a. Any deformity or loss of limb; or any disorder of the eyes, ears or throat?	☐	☑
b. Diabetes, skin disease, hernia, or any glandular disorder?	☐	☑
c. Nervous or emotional disorder, dizziness, or any disease of the brain or nervous system?	☐	☑
d. Lung disorder, asthma, or any disease of the respiratory system; or heart disease, murmur, abnormal blood pressure, stroke or any disorder of the blood?	☐	☑
e. Acquired Immune Deficiency Syndrome (AIDS); or been diagnosed by a physician as having AIDS or immune deficiency related disorder; or had a positive blood test indicating exposure to HIV?	☐	☑
f. Neuritis, arthritis, rheumatoid arthritis, gout or disorders of the muscles, of bones or joints, deformity or amputation?	☐	☑
g. Disorder or disease of the gastrointestinal system; or liver, pancreas or gall bladder disorder?	☐	☑
h. Cancer, tumor, cyst or growth of any type; or rectal disorder?	☐	☑
i. Sciatica, back pain or any disorder of the spine, back, hip or neck?	☐	☑
j. Chronic Fatigue Syndrome, Fibromyalgia, or Carpal Tunnel Syndrome?	☐	☑
k. Disorder or disease of the kidneys or genitourinary system?	☐	☑
10. Other than already noted, have you or any of the Family Members applying for coverage, within the past five (5) years:		
a. Received medical attention for any injury or sickness, or been advised to have a surgical operation which has not been performed?	☐	☑
b. Been treated for alcoholism or alcohol abuse; or used narcotics, depressants, stimulants, hallucinogenics, or marijuana, except as prescribed by a physician?	☐	☑

COMPLETE IF APPLYING FOR PERSONAL INJURY BENEFITS

	YES	NO
11. During the past three years, have you or any family member applying for this benefit been confined to a wheelchair or to bed or been required to use a walker for more than 30 cumulative days as the result of an accident?	☐	☐

GIVE DETAILS OF ANY "YES" ANSWER TO ANY PART OF QUESTIONS 9 THROUGH 11:

Ques. No.	Name of Person	Dates of onset and recovery	Nature of each injury, illness or consultation	Describe treatment or surgery	Name and address of doctor and/or hospital

Any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of insurance fraud.

I hereby apply to Pennsylvania Life Insurance Company for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete. I understand that this application shall not be binding upon the Company until approved by the Company.

The coverage I am applying for is not Workers' Compensation; a replacement for Workers' Compensation; nor an alternative to Workers' Compensation.

J. Mike Durant
Signature of Applicant

Signature of Spouse (if insured)

Lexington SC 7/5/02
City State Date

All premium checks must be payable to the Company; do not make check payable to the agent or leave payee blank.

I HEREBY CERTIFY THAT I HAVE TRULY AND ACCURATELY RECORDED ON THIS APPLICATION THE INFORMATION SUPPLIED BY THE APPLICANT.

Randolph Gill
Agent Printed Name

[signature] 100 % 173416
Signature of Licensed Agent Agent Code

Agent Printed Name

%
Signature of Licensed Agent Agent Code

Application Signed in: W. COLUMBIA, SC

PA 1900 SC Rev. 3 Page 4 6.01

PLIC 0099

ROA 1842

PENNSYLVANIA LIFE INSURANCE CO.

Home Office: Lemoyne, Pennsylvania
Executive Office: 2610 Wycliff Road,
Raleigh, NC 27607
P.O. Box 10234, Raleigh, NC 27605
(919) 786-8900 • (800) 275-7366

APPLICATION FOR RETURN OF PREMIUM INSURANCE

DATE

MO.	DAY	YEAR
7	5	02

POLICY NO. (if applicable) [redacted]9360 Date of Birth: MO DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: Mike Russell

ADDRESS: Street City State Zip Code

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☑ RETURN OF PREMIUM 1900/APP SERIES (PR-301) ☐ RETURN OF PREMIUM OTHER POLICY SERIES (PR-300)

Total Annual ROP Premium $ _____ Amount Paid With Application

Premium Mode PAC

COMPLETE FOR RETURN OF PREMIUM COVERAGE

1. Within the past two years have you or any covered family member submitted a claim on any accident or sickness policy with our Company? ☐ YES ☑ NO

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Signature of ~~Licensed~~ Agent 173416 Agent Code

Signature of 2nd Agent Agent Code

Dated at Lexington City SC State

I hereby apply to Pennsylvania Life Insurance Company for coverage to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this application shall not be binding upon the Company until approved by the Company and all delivery requirements are met.

Signature of Primary Insured

AUG 0 2 2002
NEW BUSINESS DEPT.

All premium checks must be payable to the Company; do not make checks payable to the agent or leave payee blank.

OFFICE CODE	AGENT CODE	CC	NAME	SUBAGENT CODE	CC	NAME	AMT. PAID
044425	173416		RGLC				

P-A-300 Ed. 3-97

PLIC 0100

Underwriting Worksheet

Initial review date: 7/25/02 Underwriter: R. Garcha

Name: Mike Russell File #: [redacted] 9360

Application Details

Sex: M Age: 29 Ht: 5-9 Wt: 160 lbs Smoker / Nonsmoker Alpha: Yes / (No)

Occupation & Class: Riding Stable 2A Income: $7500/M MIB: Yes / (No)

Life: 1904 → $40000/- Critical Care: 1946 $50/-

A&H: ACC: 500/M 4-7EP Sickness: 1903 → $7500 LTC / HHC:

Medical History on Application: effective 11/99
NO TIR
N/C

Requirement Findings: no declared Med hx

see over ☐

Final Action: 7/25/02
Ins approved.
[signature]

MIB Codes: / /

U/W: _____ Date: _____ Second Review: _____ Date: _____

UND-199 3.01

PLIC 0101

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

CONFIDENTIAL INCOME STATEMENT

This information is intended as additional clarification of the information provided on the application for each person applying for disability insurance, and will be held in strict confidence. None of the information contained in this statement will be released without your consent. This Income Statement once completed will be attached to the application.

SALARIED EARNINGS

OCCUPATION	INCOME
NAME (LAST NAME, FIRST NAME, INITIAL)	GROSS SALARIED INCOME LAST YEAR
TITLE	
DUTIES	SS#

SELF-EMPLOYED EARNINGS

OCCUPATION		INCOME
NAME (LAST NAME, FIRST NAME, INITIAL) Mike Russell		A. GROSS INCOME LAST YEAR 420,000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 330,000
DUTIES install vinyl siding		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS 7		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 6	SS# [redacted]	ADDITIONAL PROFITS RE-INVESTED IN BUSINESS LAST YEAR

FARM INCOME: SUPPLEMENTARY STATEMENT

NO. ACRES FARMED	CROPS GROWN
BUSHELS PRODUCED LAST YEAR	LIVESTOCK
NO. OF HEAD ON RANCH	NO. SOLD EACH YEAR

I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant.

[signature] 6/27/16

Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

Columbia SC 6/27/16

City/State Date

I hereby apply for a policy of insurance to be issued in reliance upon the written answers to the previous questions which I acknowledge as my own and to be true and complete to the best of my knowledge. I understand that this information shall not be binding upon the Company until approved by the Company.

CAUTION: If your answers on this application are incorrect or untrue, Pennsylvania Life Insurance Company has the right to deny benefits or rescind your policy.

[signature]

Signature of Applicant

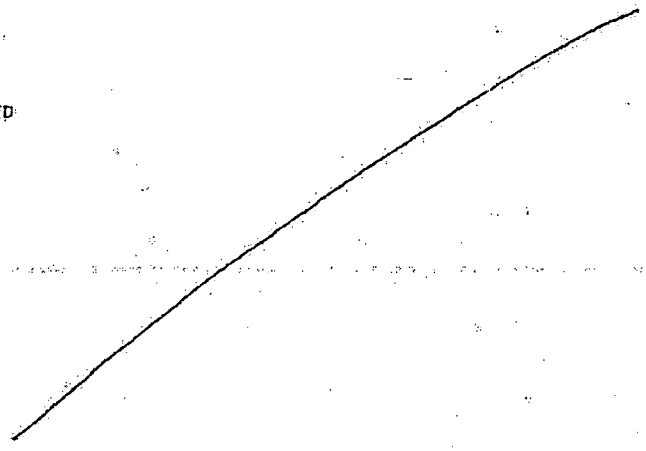
MCF-416 NC-P ED. 4-95

PLIC 0102

[redacted]9360 INSURED: RUSSELL,MIKE, UND: 07-10-02

544 010 R NFD
RUSSELL, MIKE
[redacted]9360
ILL

877 001 R NFD
RUSSELL, MIKE
[redacted]9360
ILL



PLIC 0103

Executive Fund Life Insurance Company

HOME OFFICE: Lincoln, Nebraska
EXECUTIVE OFFICE: 3130 Wilshire Boulevard, Santa Monica, California 90406

ACCIDENT SURGICAL INDEMNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is a resident patient in a Hospital; and
2. The Hospital stay is for a covered Injury; and
3. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Accident Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity, except that no amount is payable for dental treatment unless such treatment results from accidental bodily injury to natural teeth or gums. If a covered surgical procedure is performed on an Insured who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Accident Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one accident.

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for covered surgical procedures resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you: (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date, unless a different date is shown here: _____

This Rider has been signed by the President and Secretary of EXECUTIVE FUND LIFE INSURANCE COMPANY.

Secretary *President*

ER-1904 12.90

PLIC 0104

ACCIDENT SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Policy Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc

URINARY TRACT

Nephrectomy	$400.00
Nephrectomy, nephropexy, ureterotomy	$250.00
Cystoscopy for diagnosis only	$100.00
Operation for repair of urethra	$50.00

SPINE

Fracture of any vertebrae requiring removal of a portion thereof (coccyx and process excepted)	$500.00
Fracture of any vertebral process requiring removal	$250.00
Removal of nucleus pulposus or intervertebral disc	$250.00
Bone graft or fusion operation	$200.00
Fracture of sacrum or coccyx requiring open operation or removal of coccyx	$75.00

EXTREMITIES-UPPER

Amputation:

At shoulder joint or resection of shoulder	$325.00
Of arm or forearm at or above wrist or resection of elbow or wrist	$200.00
Of entire finger or any part of hand	$50.00
Of part of finger (one or two phalanges)	$50.00

Fractures, Reduction:

Of bones of arm or forearm	$150.00
Of any of the bones of wrist, hand or fingers	$50.00

Dislocations:

Reduction of dislocation of shoulder or elbow joint	$50.00

EXTREMITIES-LOWER

Amputation:

At hip joint	$500.00
Of thigh or leg at or above ankle - resection of knee or ankle joint	$250.00
Of any part of foot or complete toe	$50.00
Of any part of toe	$50.00

Fractures, Reduction:

Of femur or pelvic bones, removal of semi-lunar cartilage	$150.00
Of bone or bones of leg	$125.00
Of any of the bones of tarsus or patella	$75.00
Of any other bones of foot	$50.00

Dislocations:

Reduction of dislocation of hip or knee joint	$50.00

The amounts shown for fractures in Extremities-Upper and Lower are for simple fracture. For fractures requiring open reduction the maximum will be one and one-half times the amount for the corresponding simple fracture. For a fracture requiring an operation with bone grafting or metallic fixation at point of fracture, the maximum will be twice the amount for the corresponding simple fracture.

OSTEOMYELITIS

Osteomyelitis requiring:

Cutting operation for removal of bone other than simple curettement of infected area, bones of skull, spine, pelvis, femur, leg, humerus, forearm	$125.00
Bones of tarsus, carpus, hand or foot	$50.00
Simple incision including curettement of bones for bone infection	$50.00

MISCELLANEOUS

Suturing surface wound	$25.00
Blood transfusion—plasma	$50.00
Incision for drainage of superficial infections	$25.00

HEAD

Cutting into cranial cavity	$325.00
Reduction of fracture of maxilla (upper or lower)	$50.00
requiring wiring of teeth or bone	$125.00

EYES

Operation for detached retina	$325.00
Removal or evisceration of both eyes	$325.00
Removal or evisceration of one eyes	$150.00
Removal of foreign body from eye or eyelid	$25.00

NOSE

Reduction of fracture of nasal bones	$50.00

NECK

Tracheotomy	$75.00

CHEST

Complete pneumonectomy, lobectomy	$325.00
Bronchoscopy	$100.00
Aspiration—artificial pneumothorax	$50.00
Reduction of fracture of one or more ribs	$50.00

ABDOMEN

Gastrectomy, entero-enterostomy, splenectomy	$250.00
Intestinal resection	$250.00
colostomy, closure of perforations	$250.00
Laparotomy	$250.00
Repair of hernia, single	$150.00
double	$250.00
Gastroscopy	$75.00
Paracentesis of abdomen	$50.00

12.90

Executive Fund Life Insurance Company

HOME OFFICE: Lincoln, Nebraska
EXECUTIVE OFFICE: 3130 Wilshire Boulevard, Santa Monica, CA 90040

ACCIDENT TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT

We will pay the Monthly Total Disability Benefit shown in the Policy Schedule on Page 3 when: (1) Injury causes Total Disability which starts within 30 days after the date of the accident and continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under the Regular and Personal Care of a Physician; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Policy Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care of a Physician continues, up to the Maximum Benefit Period shown in the Policy Schedule for any one accident.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 63 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Policy was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Policy Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if Injury results in you or your Covered Spouse being confined in a Hospital as a resident patient under the Regular and Personal Care of a Physician. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for Total Disability end.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods:

(a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Policy Date, unless a different date is shown here: _____

This Rider has been signed by the President and Secretary of EXECUTIVE FUND LIFE INSURANCE COMPANY.

Secretary *President*

ER-1901 12.90

Executive Fund Life Insurance Company

HOME OFFICE : Lemoyne, Pennsylvania
EXECUTIVE OFFICE 1001 Wade Avenue, Raleigh, North Carolina 27605

ACCIDENT EMERGENCY TREATMENT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

EMERGENCY TREATMENT BENEFIT

If Injury results in a Covered Family Member receiving Emergency Treatment in a Hospital Emergency Room, we will pay two times the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will only pay this benefit once for a Covered Family Member for any one Injury.

If Injury results in a Covered Family Member receiving Emergency Treatment in an Acute Care Facility, we will pay the Emergency Treatment Benefit shown in the Policy Schedule for any one Injury. We will pay this benefit once for a Covered Family Member for any one Injury. Treatment in an Acute Care Facility is subject to a maximum of two emergency visits per calendar year for each Covered Family Member.

X-RAY BENEFIT: If the Emergency Treatment for a covered Injury includes X-rays required by a Physician, we will pay an X-Ray Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will only pay this benefit once for a Covered Family Member for any one Injury.

CAST, SPLINT OR CRUTCHES BENEFIT: If the Covered Family Member receiving Emergency Treatment requires a cast, splint or crutches as the result of a covered Injury, we will pay a Cast, Splint or Crutches Benefit equal to the Emergency Treatment Benefit amount shown in the Policy Schedule. We will pay this benefit only once, for only one of these requirements, for any one Injury. Such cast, splint or crutches must be recommended by a Physician and thereafter applied in the Hospital Emergency Room or Acute Care Facility.

AMBULANCE BENEFIT: If as a result of a covered Injury, a Covered Family Member requires transportation in an ambulance to or from a Hospital, we will pay an Ambulance Benefit equal to two times the Emergency Treatment Benefit amount shown in the Policy Schedule, for up to two trips for any one Injury.

DEFINITIONS

ACUTE CARE FACILITY means a facility providing care to patients who are not medically stable and who require frequent monitoring by health care professionals. This does not include the office of a private Physician.

ANY ONE INJURY when used in this Rider means losses incurred or medical treatment required arising out of the same accident.

CAST/SPLINT means a temporary device used to prevent motion of a joint or of the end of a fractured or broken bone. A cast/splint does not mean a brace.

CRUTCH means a support used under the armpits as an aid in walking. A crutch does not mean a cane, walker, wheelchair or other mobility device.

EMERGENCY TREATMENT means medical care for a covered Injury provided by a Physician within 72 hours of the time of the accident.

HOSPITAL EMERGENCY ROOM means a duly accredited facility set aside as such in a Hospital.

ER-1946 Ed. 5.94

PLIC 0108

The following provision is added to the ELIGIBILITY AND TERMINATION Provision of the Policy:

NEWBORN CHILDREN: While this Policy is in force, a child born of the Insured and spouse shall be covered from the moment of birth. This coverage shall continue for 31 days. We will not require evidence of insurability. This coverage applies only to benefits payable for Emergency Treatment resulting from Injury. After the first 31 days, this coverage will continue without evidence of insurability if you (1) notify us of the birth within 31 days after the date of birth; and (2) pay the additional premium, if any. If these requirements are not met, the child may be eligible for coverage under the terms of the Adding New Family Members section of the Policy.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After two years from the Rider effective date, only fraudulent misstatements made by you in the application for this Rider shall be used to void the Rider or to deny a claim for loss incurred commencing after the expiration of such two-year period.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement. If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Injury sustained after the date of reinstatement, subject to any provisions endorsed on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the date shown in the Policy Schedule issued with it.

This Rider has been signed by the President and Secretary of EXECUTIVE FUND LIFE INSURANCE COMPANY.

Secretary

President

ER-1946 Ed. 5.94

THIS IS A SICKNESS ONLY RIDER AND DOES NOT PAY BENEFITS FOR LOSS FROM ACCIDENTS

Executive Fund Life Insurance Company

HOME OFFICE: Lincoln, Nebraska
EXECUTIVE OFFICE: 3130 Wilshire Boulevard, Santa Monica, California 90406

In this Rider, the person named as the Insured in the Rider Schedule will be referred to as "you," "your" or "the Insured."
The person named as the spouse in the Application will be referred to as "Covered Spouse"

SICKNESS TOTAL DISABILITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

TOTAL DISABILITY BENEFIT FOR SICKNESS

We will pay the Monthly Total Disability Benefit shown in the Rider Schedule on Page 3 when: (1) Sickness causes Total Disability which continues through the end of the Elimination Period, if any; (2) you or your Covered Spouse are under a Physician's Regular and Personal Care for Sickness; and (3) Total Disability starts before your, or your Covered Spouse's, 65th birthday (or starts within two years after the Sickness Rider Date for coverage issued to persons age 63 and over). This benefit is payable for each month during which such Total Disability with Regular and Personal Care for Sickness continues, up to the Maximum Benefit Period shown in the Rider Schedule for any one period of sickness.

CONTINUATION OR TERMINATION OF TOTAL DISABILITY BENEFITS

Total Disability coverage will terminate on your, or your Covered Spouse's, 65th birthday. However, if you or your Covered Spouse continue to be employed on a full-time basis after age 65, we will continue Total Disability coverage for that person, if you provide evidence of such full-time employment satisfactory to the Company. Such evidence of full-time employment must be submitted to the Company prior to the termination of coverage. However, such continuation of Total Disability coverage will terminate on your, or your Covered Spouse's, 70th birthday (72nd birthday for coverage issued to persons age 68 and over).

Termination of Total Disability coverage shall be without prejudice to any continuous loss which commenced prior to the termination date described above and which began while this Rider was in force. But, such extension of Total Disability benefits will be predicated upon the continuous Total Disability of you or your Covered Spouse, and shall be limited to the duration of the Maximum Benefit Period and all applicable provisions of the Policy and Rider.

HOSPITAL CONFINEMENT BENEFITS UPON TERMINATION OF TOTAL DISABILITY BENEFITS

When Total Disability coverage has terminated for you or your Covered Spouse in accordance with the above provision, a daily Hospital Confinement Benefit of $10.00 per day for every $300 amount of the monthly Total Disability Benefit shown in the Rider Schedule will be provided for that person.

This Hospital Confinement Benefit is payable from the first day of hospitalization if Sickness results in you or your Covered Spouse being confined in a Hospital as a resident patient under a Physician's Regular and Personal Care for Sickness. We will only pay for Hospital confinement recommended by a Physician.

Should you or your Covered Spouse be Totally Disabled, the Hospital Confinement conversion will not go into effect until benefits payable for such Total Disability ends.

TOTAL DISABILITY BENEFITS MAY END AT AGE 65

RECURRENT DISABILITIES

If a Period of Disability is due to the same or related causes of a prior period, it may be a continuation of the prior period. This depends on how much time has passed between periods:

(a) If less than 180 days have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts, it will be a continuation of the prior period. The benefit rate will resume at the point at which the prior benefit payments ended.

(b) If 180 days or more have passed from the end of a prior Period of Disability to the date a subsequent period due to the same or related causes starts and you or your Covered Spouse have returned to full time employment for at least 180 days, the subsequent period will be a new Period of Disability. Such new Period of Disability will be subject to the Elimination Period, if any.

DEFINITIONS

REGULAR AND PERSONAL CARE FOR SICKNESS means a planned program of observation and treatment requiring personal attendance by a Physician. Once started, this program must be continued under the existing standards of medical practice for treatment of the sickness.

SICKNESS RIDER DATE means the date this Sickness Rider is effective. This date is shown on the Rider Schedule.

SICKNESS means sickness or disease first manifesting itself: (1) more than 30 days after the Sickness Rider Date; and (2) while this Rider is in force.

PRE-EXISTING CONDITION LIMITATION

This Rider will not cover a loss that: (1) starts within two years after the Sickness Rider Date; and (2) is caused by a Pre-existing Condition.

"Pre-Existing Condition" means a condition for which: (1) symptoms existed within a five year period preceding the Sickness Rider Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) medical advice or treatment was received from or recommended by a Physician within a five year period preceding the Sickness Rider Date.

ADDITIONAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: (a) After this Rider has been in force for two years, misstatements in the Application, unless fraudulent, will not be used to: (1) void the Rider; or (2) deny a claim for loss incurred or disability that starts after the two-year period.

(b) No loss that starts more than two years after the Sickness Rider Date will be reduced or denied on the grounds that a disease or physical condition has existed before the Sickness Rider Date.

RIDER REINSTATEMENT: If this Rider has ended due to an unpaid renewal premium, the Policy may provide for reinstatement. If you choose to reinstate this Rider and it is approved by us, the reinstated Rider will cover only loss due to Sickness beginning 10 days after the date of reinstatement, subject to any provisions noted on or attached to the reinstated Rider.

Other than as stated above, this Rider shall not alter, waive or extend any other provision of the Policy.

This Rider is effective on the Sickness Rider Date, unless a different date is shown here: _____

This Rider has been signed by the President and Secretary of EXECUTIVE FUND LIFE INSURANCE COMPANY.

Secretary *President*

ER-1911 12.90

Executive Fund Life Insurance Company

HOME OFFICE: Lincoln, Nebraska
EXECUTIVE OFFICE: 3130 Wilshire Boulevard, Santa Monica, California 90406

ADDITIONAL SURGICAL RIDER FOR SICKNESS

This Rider is made a part of the Policy to which it is attached and the Accident Surgical Indemnity Rider. It is issued in consideration of your application and the payment of the first premium. All definitions, provisions, exceptions and limitations of the Policy apply to this Rider, except as modified in this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

SURGICAL INDEMNITY BENEFIT

The Surgical Benefit as scheduled below is payable when:

1. A Covered Family Member is also covered under the Policy's Accident Surgical Indemnity Rider.
2. The Covered Family Member is a resident patient in a Hospital; and
3. The Hospital stay is for a covered Sickness; and
4. The Covered Family Member undergoes a covered surgical procedure performed by a Physician while this Rider is in force.

Procedures not listed in the Surgical Schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity. If a covered surgical procedure is performed on a Covered Family Member who is not a resident patient in a Hospital, we will pay one-half (1/2) of the amount set forth in the Surgical Schedule.

Only one amount, the largest applicable, will be paid if more than one surgical procedure is performed as the result of any one sickness or any one accident.

ADDITIONAL DEFINITIONS

REGULAR AND PERSONAL CARE FOR SICKNESS means a planned program of observation and treatment requiring personal attendance by a Physician. Once started, this program must be continued under the existing standards of medical practice for treatment of the sickness.

SICKNESS means sickness or disease first manifesting itself: (1) more than 30 days after the Sickness Rider Date; and (2) while this Rider is in force.

SICKNESS RIDER DATE means the date this Sickness Rider is effective. This date is shown on the Rider Schedule.

PRE-EXISTING CONDITION LIMITATION

This Rider will not cover a loss that: (1) starts within two years after the Sickness Rider Date; and (2) is caused by a Pre-existing Condition.

"Pre-Existing Condition" means a condition for which: (1) symptoms existed within a five year period preceding the Sickness Rider Date which would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) medical advice or treatment was received from or recommended by a Physician within a five year period preceding the Sickness Rider Date.

AT IONS TO SURGICAL SCHEDULE

The amount specified is the amount payable if the Maximum Surgical Benefit shown in the Rider Schedule on Page 3 is $500.00. If such Maximum Surgical Benefit is greater than $500.00, the amounts specified below will be increased proportionately. For example: If the Maximum Surgical Benefit is $1,000.00 the amounts below will be two times the amounts specified; if the Maximum Surgical Benefit is $1,500.00, the amount below will be three times the amount specified; etc.

URINARY TRACT	
Cystoscopy-operative procedure for removal of stone or tumor	$150.00
SPINE	
Radical operation for pilonidal cyst	$ 50.00
TUMORS	
Cutting operation for removal of:	
Malignant tumors except those of face, lip or skin	$325.00
Malignant tumors of face, lip or skin	$ 75.00
Benign tumors	$ 50.00
Superficial tumors such as sebaceous cysts, fibromata lipoma, ganglia, enlarged lymph glands	$ 50.00
Removal of tissue for biopsy	$ 25.00
MISCELLANEOUS	
Removal of nerve of ganglion for fifth nerve tic	$250.00
Varicose veins, cutting	$ 75.00
injections	$ 50.00
Cutting operation for boils and carbuncles	$ 25.00
Felons or superficial abscess	$ 25.00
Excision of surface ulcers	$ 25.00
Operation for stretching of nerve	$ 50.00
HEAD	
Removal of brain tumor or drainage of brain abscess	$500.00
Trephining (skull)	$250.00
EYES	
Cataract Extraction with IOL (intra-ocular lens)	$335.00
Extraction of cataract	$250.00
Operation on external muscles of eye, sclerotomy, iridectomy	$100.00
Removal of chalazion, pterygium or foreign body from eye or eyelid	$ 25.00
EAR	
Fenestration	$400.00
Mastoidectomy—single	$200.00
double	$250.00
Removal of polypus	$ 50.00
Paracentesis or myringotomy	$ 25.00
NOSE	
Submucous resection	$100.00
Radical operation on sinuses	$150.00
Maxillary sinus puncture for drainage	$ 50.00
Removal of nasal polypus	$ 25.00
THROAT	
Excision of larynx—esophagostomy	$250.00
Tonsillectomy and (or) adenoidectomy	$ 75.00
Incision of peritonsillar abscess	$ 25.00
NECK	
Thyroidectomy	$250.00
CHEST	
Coronary Artery Bypass	$500.00
Thoracoplasty	$325.00
Breast - radical operation, one	$150.00
both	$325.00
Empyema - lung abscess requiring rib resection, phrenic nerve crushing or excision	$200.00
Bronchoscopy	$100.00
Removal of benign tumor or tumors from breast	$ 75.00
ABDOMEN	
Gastro-enterostomy, cholecystectomy, cholecystotomy	$250.00
Intestinal resection	$250.00
abscess, closure of perforated gastric or duodenal ulcer, operations requiring opening of bile ducts	$250.00
PELVIS	
Cutting into abdominal or pelvic cavity for diagnosis or treatment including hysterectomy, myomectomy of uterus, oophorectomy, salpingectomy, uterine fixation or removal of ovarian or broad ligament cysts	$250.00
Repair of recto-vaginal or vesica-vaginal fistula	$150.00
Operations on uterus and its appendages without abdominal approach; rectocele, cystocele	$125.00
Dilation and curettage, including removal of polypi or cysts from cervix	$ 75.00
RECTUM	
Proctectomy, prolapse of rectum	$250.00
Radical operation for internal hemorrhoids, fistula in ano or stricture, including perirectal abscess	$ 75.00
Excision of fissure	$ 50.00
Operation for cure of external or mucocutaneous hemorrhoids	$ 50.00
MALE GENITAL ORGANS	
Prostatectomy (including preliminary drainage of bladder) by open operation	$250.00
Prostatectomy by trans-urethral resection	$150.00
Radical operation for hydrocele, varicocele, undescended testicle, orchidectomy	$100.00
Paracentesis of scrotum	$ 25.00

PLIC 0114

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike
Russell

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER | L | REVIEW DATE | PAY TYPE: B

DATE: 3/12/10

Rus

CLAIM NUMBER: 0809-03062

CSIE	CNCO	DATE INCURRED
SEE CLAIM NUMBER		CHANGE TO:

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted] 9360	0120	8090			✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12		012510	022510			
4	12		012510	022510			

MANUAL DRAFT NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0115

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
MAR 05 2010
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 03-001-001-080900062
	~~Work~~ Cell	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability. motorcycle accident - broken leg + hip	
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr - Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	Dr. Odom - 1-8-10 Dr. Suarez - 2-25-10
4. Have you been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital _____ Address _____ Admitted: _____ Discharged _____
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☐ YES, I have been confined to the house since completing my last report. ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 3-1-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0116

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) total h.p. 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) tib/fib rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 1/28/10, 2/25/10
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 2-25-10 SIGNED: Randall S. Bragg, MD

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

TELEPHONE

C-3 R

Rev. 3-96

PLIC 0117

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0003956761 MAR 01 2010
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310372290	02/12/10	4210046455	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210046455
CHECK DATE 02/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 02-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310372290

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-09	01-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	11-25-09	01-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	50,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0119

Advisor: Ella Lee
Claim #: 0809-00062
Date: February 8, 2010

APP ROVAL(S) NEEDED

- [x] Over Limit
- [ ] Denial (Please have denial letter in file)
- [ ] IME Date of Last IME:
- [ ] FCE, [ ] VOC EVAL, and/or [ ] TSA Date of last:
- [ ] MED Recs Invoice over $100
- [ ] Surveillance From/To Dates:
- [ ] TCR Referral
- [ ] MRI
- [ ] Reopen (Summary should be attached)
- [ ] L-Card Placement (Summary should be attached)
- [ ] Contestable
- [ ] Other (Please specify):

Question:

Advisor Opinion:

Reviewer recommendations:

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Miles Russell

DATE: 2/8/10

RW

CLAIM NUMBER: 0809-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME:

SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L	REVIEW DATE	PAY TYPE
	02/10/10	B

CSIE	CNCO
SEE CLAIM NUMBER	

DATE INCURRED
6/18/08
CHANGE TO:

CW

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted]9360	0120	8060	5010		✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12		1.1.2504	@1.2510			
4	12		1.1.2509	@1.2510			

MANUAL DRAFT NUMBER BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0121

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER JAN 29 2010 PENSACOLA

MIKE RUSSELL
1
w 2

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	955-0329	Age: 37	Claim No: 02-001-001-080900062
	~~Work~~ Cell	803-513-0575		Policy No [redacted] 9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg and hip

2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - 1-18-10
   Dr. Suarez - 12-17-09

4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital _____
   Address _____
   Admitted: _____ Discharged _____

5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed: _____

7. When do you expect to begin working at all of your duties?
   Unknown

8. Have you been confined to the house since completing your last report?
   (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, watching TV, completing exercises, reading, etc.

DATE: 1-25-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R Rev. 4-97

PLIC 0122

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/p (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/p (L) tkb / fib rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 12-17-09
3a Next Appointment Date: 1-28-10	Patient discharged on: ____
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital ____ Address ____ Admitted: ____ Discharged ____
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

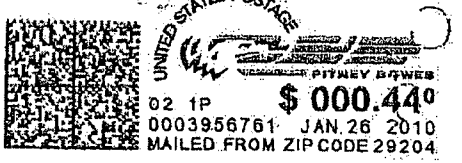
DATE: 1/20/10 SIGNED: Randall S Stacy, MD PA

ADDRESS: Lexington Orthopaedics 146 N. Hospital Drive, Ste.140 West Columbia, SC 29169 (803) 936-7230 TELEPHONE ____

C-3 R

Rev. 3-96

PLIC 0123



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0124

ROA 1866

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310369612	01/12/10	4210043769	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210043769
CHECK DATE 01/12/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 01-12-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310369612

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	09-25-09	11-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	09-25-09	11-25-09	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		45,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0125

PENNSYLVANIA LIFE INSURANCE CO.

January 12, 2010

Mike Russell

RE: Policy No: [redacted]9360
Claim No: 0809-00062

Dear Mr. Russell:

Shortly, you will be receiving a benefit payment based on the latest supplemental claim form we received.

While we continue to make payment based on the supplemental information and how it relates to the injury sustained on 06/18/08, please be advised, we are reserving our rights under your policy provisions and not setting precedence for future claims.

If you have any questions, please contact this office at 1-888-399-8847, ext. 2492.

Sincerely,

Ella Lee
Disability Claims Advisor
Claims Department

cc: File

PO Box 12355, Pensacola, FL • (Tel) 1-888-399-8847 (Fax) 1-850-432-6077

11/13/10

PLIC 0126

Advisor: Ella Lee
Claim #: 0809-00062
Date: January 12, 2010

APP ROVAL(S) NEEDED

- ☐ Over Limit
- ☐ Denial (Please have denial letter in file)
- ☐ IME Date of Last IME:
- ☐ FCE, ☐ VOC EVAL, and/or ☐ TSA Date of last:
- ☐ MED Recs Invoice over $100
- ☐ Surveillance From/To Dates:
- ☐ TCR Referral
- ☐ MRI
- ☐ Reopen (Summary should be attached)
- ☐ L-Card Placement (Summary should be attached)
- ☐ Contestable
- ☒ Other (Please specify): Letter approval

Question:

Advisor Opinion:

While we Continued to make Pymt in reference

Reviewer recommendations:

Wee are reserving rights & not setting precedence for future claims. The letter should read while we continue to make payments based on supplemental information & how it relates to the injury you sustained on 6/18/08. Please be advised we are reserving our rights under your policy not setting precedence for future claims

PLIC 0127

Advisor: Ella Lee
Claim #: 0809-00062
Date: January 6, 2010

APP ROVAL(S) NEEDED

- [x] Over Limit
- [ ] Denial (Please have denial letter in file)
- [ ] IME Date of Last IME:
- [ ] FCE, [ ] VOC EVAL, and/or [ ] TSA Date of last:
- [ ] MED Recs Invoice over $100
- [ ] Surveillance From/To Dates:
- [ ] TCR Referral
- [ ] MRI
- [ ] Reopen (Summary should be attached)
- [ ] L-Card Placement (Summary should be attached)
- [ ] Contestable
- [ ] Other (Please specify):

Question:

Advisor Opinion:

Reviewer recommendations:

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Russell

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER | L | REVIEW DATE | PAYTYPE
| | | 1/11/10 | B

DATE: 1/6/10

RJS

CLAIM NUMBER: 0809-00062

CSIE	CNCO	DATE INCURRED
SEE CLAIM NUMBER		06/18/08
		CHANGE TO:

CC

POLICY [redacted]9360	NATURE 0120	ADJUSTOR	REVIEWER	AUDITOR	PART ✓	PINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	O/R
2	13		092509	112509			
4	12		092509	112509			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0129

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	**DATE AND TIME: 01/06/10, 12:39 pm**	
Policy Number and Policy Form: [redacted]9360		
Claimant Name: Mike Russell		
Caller Name: Insured		
Telephone Number: 803-513-0575	**Incoming?**	**Outgoing? XXXX**
Alternate Telephone Number:	**Claim Number: 0809-00062**	

NATURE OF CALL

Called the insured back informing him that the claim will stay active until his release to return to work.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

Signature: Ella Lee	Date: 12/06/10

PLIC 0130

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	**DATE AND TIME: December 31, 2009**	
Policy Number and Policy Form: [redacted]9360		
Claimant Name: Mike Russell		
Caller Name: Insured		
Telephone Number: 803-513-0575	**Incoming?**	**Outgoing? xxxx**
Alternate Telephone Number:	**Claim Number: 0809-00062**	

NATURE OF CALL

12/30/09 received a message from insured for status
12/31/09 Called insured back. Informed him that his claim is currently being reviewed due to the current medical records we received stating he was intoxicated at the time of the accident. His policy has an exclusion for intoxication. He said he was cleared of all of the charges of intoxication. I informed him that he never made us aware of it at the onset of his claim. At this time, it is being reviewed and I will keep him posted. He then said he was getting a lawyer and hung up.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

INformed insured when I called back on 1/6/10-see note

Signature: Ella Lee	Date: 12/31/09

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER

DEC 08 2009

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]9360

1. Describe the conditions causing your disability. motorcycle accident- broken leg + hip	
2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063	Dr. Suarez + Dr. Dedmond- Lexington Ortho. 146 N. Hospital Dr Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report? Dr Odom- Oct 26	Dr. Dedmond- Oct. 26 Dr. Suarez Oct. 29, Nov. 10
4. Have you been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. Have you performed any work or activities since completing your last report?	☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.	Describe work or activities: Date these duties first performed:
7. When do you expect to begin working at all of your duties?	Unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)	☑ YES, I have been confined to the house since completing my last report. ☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

Resting, Watching TV, completing exercises, reading, etc.

DATE: 12-2-09 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0132

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	S/P (L) Total Hip 715.15
2. Describe any other conditions contributing to present disability.	S/P (L) Tib/fib fx - rodding
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09, 10-29-09, 11-10-09
3a Next Appointment Date:	Patient discharged on: No
4. Has the patient been confined to a hospital since completing your last report? No (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity?	Unknown
6. When did or will your patient be able to resume full work?	Unknown
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 11-30-09 SIGNED: Randall S. Stuart, M.D.

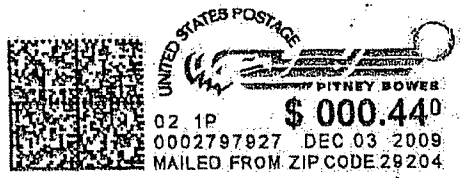
ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive, Ste 140
West Columbia, SC 29169
(803) 936-7[illegible]

TELEPHONE

C-3 R

Rev. 3-96

PLIC 0133



PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1876

PLIC 0134

Referral to Medical Director

Date: 12/7/09 Claim No.: 0809-00062

Insured: Mike Russell Age: 35 Sex: M Occupation: Construction

Policy No. [redacted]-9360 Coverage: _____ Date of Onset: 6/18/08

Initial Diagnosis: 808.0

Contributing Factors: Motorcycle Accdnt Impairment Rider: N/A

Date (Chronological)	Summary of DX, Tests, Consults SX. RX. TX, Complications ect.
	Dr Nye,
	Thank for for your response (no date) on Mr Russell.
	You stated his blood alcohol was 0.232 per records receive from Lexington Ek. on 6/18/09.
	You also requested blood work for alcohol levels. Can you please clarify? ~~what records~~
	Also, please mark where you found the info on the 0.232 alcohol level?
	Thank
	Ella
	Per Dr. Nye verbally, he was referring to Rec we already have. No other info needed 12/11/09

Page

PLIC 0135

Claim Review

Advisor: Ella Lee

Date: 12/7/09

Reviewed By: Christina Carwile

Policy # [redacted] 9360

Claim # 0807 00062

☐ 45 day ☐ 60 day ☐ 120 day ☐ 1 year ☑ Other

Claimant: Mike Russell

Comments: You will need to order ER records. Pull policy & see what if any alcohol exclusion there is. Search State laws on RAC. We will need to discuss once all has been received.

1/6/10

REDACTED

Ella Lee

ZC-120

2/07

Field Adjuster's Report

From: Bill Maloney

Date of Dictation: November 23, 2009

Attention: Ella Lee

Date of Contact: November 18, 2009

Claimant: Mike Russell

Handled at: West Columbia, SC

Policy Number: [redacted]9360

Company: PLIC

Claim #: 0809-00062

Incurred Date: June 18, 2008

RECEIVED
DEC 04 2009
PENSACOLA DISABILITY CLAIMS

Diagnosis: Fx. Left Hip

Question involved: Update file. What are his current activities? Who is operating the business?

Residence Description

Mr. Russell resides in a rural area. His residence is a two-story home. The residence appears to be five to seven years old. The property is well maintained.
Two images were obtained of the residence/yard.

A white dual wheel flat bed truck, license tag: P381867 SC was parked on the right side of the driveway. It appeared that the vehicle had not been moved for awhile.

At the end of the driveway was another construction truck with several ladders on the top of the truck.

I arrived at the residence at 12:15 PM. I was parked in the driveway reviewing the file.

Shortly after I arrived, I observed a pickup truck pull in behind me. There were 3 occupants in the vehicle. The driver was Mr. Russell. The female was his wife, Susame. The other occupant was a male who appeared to be approximately 35 to 40 years of age. I was not introduced to him. This individual walked into the house. He was there for a short time and then he left. Mr. Russell had just returned from a relative's funeral in Tennessee.

Physical Description:

Mr. Russell advised that he is 5'10' and weighs 185 pounds. He was ambulating with the aid of a cane when he exited the vehicle. From a layman's observation, Mr. Russell had a distinct limp when ambulating. Mr. Russell was attired in a brown pullover T-shirt with the letters NRA on the left side of the pullover shirt and a pair of sweatpants. He was clean-shaven and had short brown hair. Other than the above description, there were no notable characteristics. See enclosed photo of Mr. Russell.

Interview:
Mr. Russell invited me into the residence. The interview took at the kitchen table. The parties present were Mr. and Mrs. Russell. Mr. Russell had no objection to his wife's presence during the interview.

Mr. Russell advised me that he was involved in a two vehicle crash on June 18, 2008. He advised me that he was driving a motorcycle and was involved in the automobile crash.

Both drivers were ticketed. The other driver took her case to court, had a jury trial and won her case. Mr. Russell's lawyer told him that it would be very costly for him to take his case to court. There are no lawsuits or third party actions pending.

Mr. Russell was first taken to Lexington Hospital after the accident. Lexington Hospital was not prepared to handle his case so he was transported to Richland Hospital, Columbia, South Carolina. He was hospital confined from June 20, 2008 to July 1, 2008.

He stated that they placed a metal plate in his left hip, and metal rods in his leg. All his injuries are on the left side. He states that he still has a plate in his pelvic bone. Mr. Russell also reported that he has a large rod in his left lower leg between the knee and the ankle.

Mr. Russell stated that he had his left hip replaced in October 2009. He said that he underwent physical therapy for approximately 2 weeks after the hip replacement. The doctor has given him home exercises to do. He stated that the left hip replacement has cut his hip pain in approximately one half. He still has problems with the left ankle and knee.

Mr. Russell reported that last week he had a MRI on the left knee, however, the physicians advised that they were not able to read it clearly because of the probable scar tissue. He stated the doctor said they could do an exploratory surgery, but did not know if this would be of any benefit to him or not. At the present time, he has no plans to undergo any further surgery on the hip, knee, ankle. Etc.

His treating physicians are:
- Dr. Randall Suarez Hip
- Dr. Barnaby Dedmond Leg

Both of the above doctors are located in the Lexington Orthopedic Center, West Columbia, SC.

- Dr. William Odom, Pain Management, 7921 Broad River Road, Irmo, SC 29063

Medications:
Hydrocodone AP 10-500 1 tab 4 times per day.
He cannot drive if he takes the pain medication.

Mr. Russell said that he was on blood thinner prior to the last surgery. The blood thinner has been discontinued.

Current Activities:
Mr. Russell generally arises approximately 7:30 AM depending on how he slept. He stated that the hip and leg pain interfere with his sleep.

He said he could be on his feet for one to one half-hours per day. He is able to drive a vehicle. He can drive for approximately two hours per day. He walks around his yard frequently to build up the muscles in his leg.

He is very limited in the amount of yard work he can do. He stated "most of the time I just sit in the house".

Education:
Mr. Russell has no other employment history. He is not computer literate. Mr. Russell completed the eighth grade. Mr. Russell is not engaged in any type of Rehab training. He was thinking about getting his GED.

Employment
He stated that his father was killed when he was in eighth grade. He had to quit school and go to work.

He stated that he has been working construction/house siding ever since that time. He has been self-employed. Mr. Russell had no other employment. He has no employees.

Mr. Russell advised that all of his work is of a physical nature. He stated that most of his work is siding new homes. He said that he has worked 13 years with a home building contractor, Mungo Homes, in Irmo, SC. His duties required him to stand on ladders, scaffolds, etc. He was constantly going up and down ladder steps.

Mr. Russell had full time work with Mungo Homes. He said he does not know if they will have work for him when or if he is able to return to work. His company is MCL Construction Co. LLC. Mrs. Russell stated that their Company is an S-Corporation.

He and his wife own the company. His wife is a CPA at Barb & Company. She works full time at Barb & Company.

Past Medical History:
Other than the injuries from the motor vehicle crash, Mr. Russell advised that he had no other impairments.

Military:
Mr. Russell has never served in the US Armed Forces.

Other Income;
Mr. Russell has no other disability or loss of time insurance. He recently applied for SSD and was denied benefits. He said that he is going to appeal the SSD decision.

Income:
Mrs. Russell advised his income would be approximately $4300.00 a month when he was working. Other than Mrs. Russell's income, they have no other household income.

Summary:
Mr. Russell has no idea when he can return to any type of work. He stated his job skills are very limited. He cannot type. His business is shut down.

He is hopeful that he will recover to the extent that he can return to some type of employment.

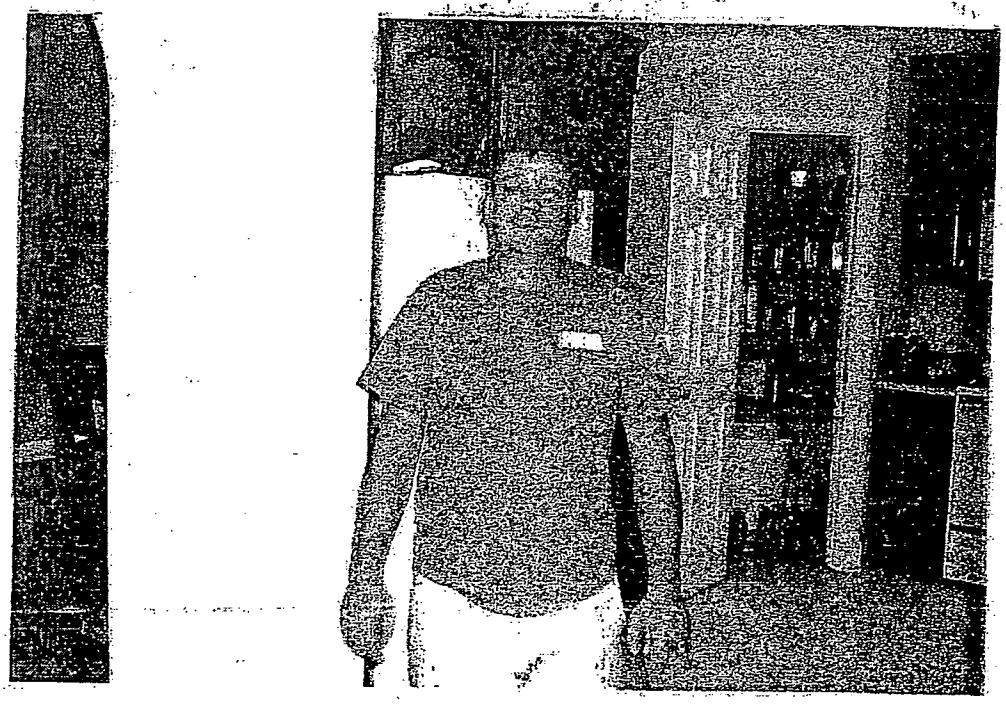
I secured his signature on a HIPPA Authorization and on a 4506 IRS Tax Release Form.

Mr. & Mrs. Russell inquired about the 4506 tax form. I told them that the Company needs to verify his income. Mrs. Russell advised that they file their taxes jointly. If the company has any questions about the tax forms, they are to call her.

I mentioned a final settlement to them. They said they would keep this in mind.

This concludes the handling of this assignment.

Enclosures:
Image of Mr. Miller
Image of Mr. Miller's residence
Image of Mr. Miller's residence/yard
HIPPA Authorization
IRS Form 4506 -Request for Copy of Tax Return

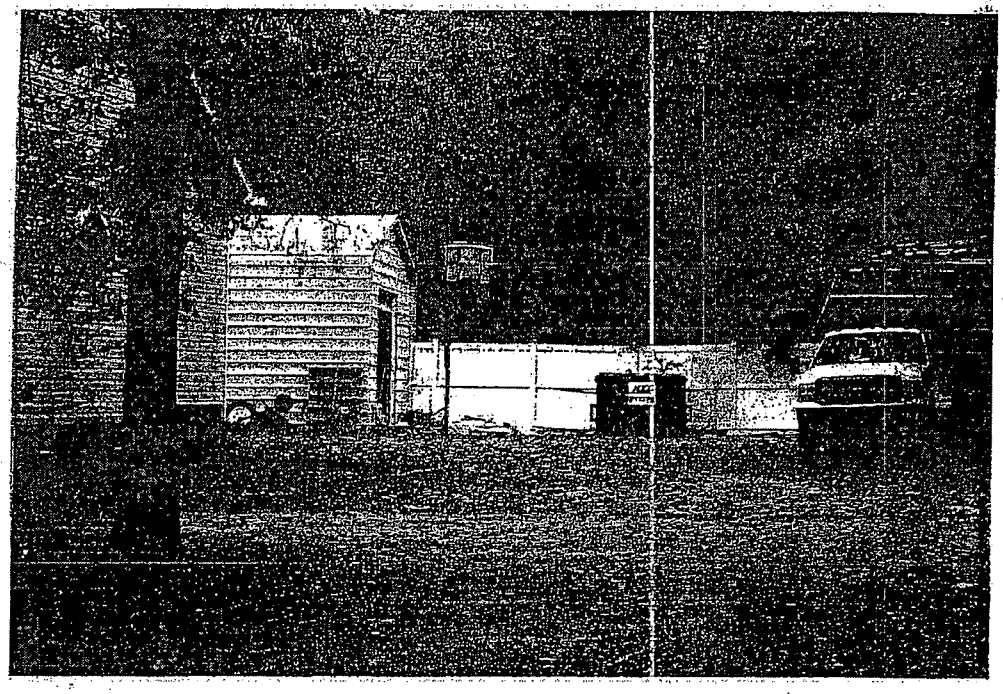


Michael Russell 11/18/2009 [redacted]9360



Michael Russell 11/18/2009 [redacted]9360 Residence

PLIC 0141



Michael Russell 11/18/2009 [redacted]9360 Residence/Yard

PLIC 0142

Pennsylvania Life Insurance Comp
www.pennlife.com

HIPAA Authorization Addendum

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB Group, Inc., employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Pennsylvania Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's " Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to The Company's Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke is also subject to the rights of The Company under any law granting The Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Patient's Name:

X Michael (First) C (Middle) Russell (Last)

Other Names Used:

Date of Birth: [redacted] X Social Security Number: [redacted]

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18)

X Mike Russell — Date: 11-18-09

Signature of Spouse:
(If applying for coverage) — Date:

Signature of Authorized Representative: — Relationship: — Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AA-0403

PLIC 0143

Form **4506**

(Rev. October 2008)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.

▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
Mike Russell	[redacted]
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Pennsylvania Life Insurance, P.O. Box 12355, Pensacola, FL 32591, ATTN: Ella Lee, 888-399-8847, extension 2492.

Caution: *DO NOT SIGN this form if a third party requires you to complete Form 4506, and lines 6 and 7 are blank.*

6 **Tax return requested.** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1120

Note. *If the copies must be certified for court or administrative proceedings, check here* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

12 / 31 / 07	/ /	/ /	/ /
12 / 31 / 08	/ /	/ /	/ /

8 **Fee.** There is a $57 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a	Cost for each return	$ 57.00
b	Number of returns requested on line 7	2
c	Total cost. Multiply line 8a by line 8b	$ 114.00

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here	X Mike Russell Signature (see instructions)	11-18-09 Date	Telephone number of taxpayer on line 1a or 2a (808) 955-0329
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Susanne C. Russell Spouse's signature	11-18-09 Date	

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 41721E Form **4506** (Rev. 10-2008)

PLIC 0144

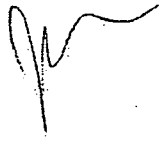
In thinking in 2000 and

Review and record of: Mike Russell. eight of Birth: [redacted]

Mr. Russell is a 35-year-old owner of a construction company who was involved in an accident on 06/18/2008. Please see previous review dated July 16, 2009

Thank you for obtaining the additional records I requested. According to the medical records, dated 06/18/2008, of Mr. Mike Russell, his blood alcohol was 0.232 which is well above the level of 0.08 which typically is utilize for determining driving under the influence of alcohol. Mr. Russell is now nearly a year and a half after the accident, and was recently diagnosed with avascular necrosis on the femoral head. This is not real rare and is more commonly seen after motor vehicle accidents, after steroid treatment for mixed connective tissue diseases (such as lupus or rheumatoid,) it can occur after a dislocation of the femur, or even noting and alcohol. There are many other causes too. Depending on how significant or large of area of the avascular necrosis, determines how soon the symptoms began in that determines how soon the treatment begins. There are many people would avascular necrosis who continue on without any treatment. Also, many who have been treated with a joint replacement continue on to their previous activities. At this point, the patient is still in a recuperative timeframe and he underwent surgery on 05/08/09 for nonunion of his left tibia. This would require an additional six months at least , which would take it to around 11/8/2009 or approximate right now. He eventually will be evaluated by a specialist for the avascular necrosis. He currently should be considered temporarily disabled. Again , it is noteworthy the results of the blood work, specifically the blood alcohol level. It would be a medical significance to find if a drug screen was performed at the time of his arrival in the emergency room.

John David Nye, M.D. Medical Direct



Referral to Medical Director

Date: 11/9/09 Claim No.: 0809-0006 a

Insured: Mike Russell Age: 35 Sex: M Occupation: Construction

Policy No. [redacted]9360 Coverage: _____ Date of Onset: 6/18/08

Initial Diagnosis: 808.0 fx acetabulum, upper tibia and fibula

Contributing Factors: Motorcycle Accident Impairment Rider: N/A

Date (Chronological)	Summary of DX, Tests, Consults SX. RX. TX, Complications ect.
	Dr. Nye,
	Insured was in an accident as noted previously. (Please see your previous answers). He received a new diagnosis of Aseptic necrosis. In your medical opinion, could the latest diagnosis be connected with the accident of 6/18/08?
	Also, please see the attached records from Lexington Medical Center. Please note, ~~the~~ self the insured was/was not intoxicated at the time of injuries.

Page _____

PLIC 0146

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mr Lubell

DATE: 10/9/09

bus

CLAIM NUMBER: 0809-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME:

SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L | REVIEW DATE | PAY TYPE: B

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED: 06/18/08
CHANGE TO:

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted]4360	6120	[illegible]			2							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12		092509	092509			
4	12		092509	092509			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0147

Avascular necrosis

From Wikipedia, the free encyclopedia
(Redirected from Aseptic bone necrosis)

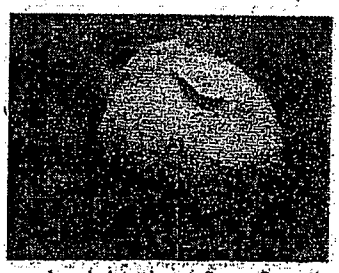
Avascular necrosis (also **osteonecrosis, aseptic (bone) necrosis, ischemic bone necrosis**[1], and **AVN**) is a disease resulting from the temporary or permanent loss of the blood supply to an area of bone.[1] Without blood, the bone tissue dies and the bone collapses.[1] If avascular necrosis involves the bones of a joint, it often leads to destruction of the joint articular surfaces (see Osteochondritis dissecans).

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Avascular necrosis

Classification and external resources



Femur head showing a flap of cartilage (osteochondritis dissecans) due to avascular necrosis. Specimen from total hip replacement surgery.

ICD-10	M87.
ICD-9	733.4
DiseasesDB	1174
eMedicine	med/2924
MeSH	D010020

Causes

There are many theories about what causes avascular necrosis. Proposed risk factors include alcoholism,[2] excessive steroid use,[3] post-trauma,[4][5] caisson disease (decompression sickness),[6][7] vascular compression,[8] hypertension, vasculitis, thrombosis, damage from radiation, bisphosphonates (particularly the mandible),[9] sickle cell anaemia,[10] and Gaucher's Disease.[11] In some cases it is idiopathic (no cause is found).[12] Rheumatoid arthritis and lupus are also common causes of AVN. Prolonged, repeated exposure to high pressures (as experienced by commercial and military divers) has been linked to AVN, though the relationship is not well-understood.

Presentation

While it can affect any bone, and half of cases show multiple sites of damage, avascular necrosis primarily affects the joints at the shoulder, knee, and hip.

Clinical avascular necrosis most commonly affects the ends (epiphysis) of long bones such as the femur (the bone extending from the knee joint to the hip joint). Other common sites include the humerus (the bone of the upper arm),[13][14] knees,[15][16] shoulders,[13][14] ankles and the jaw.[17] The disease may affect just one bone, more than one bone at the same time, or more than one bone at different times.[18]

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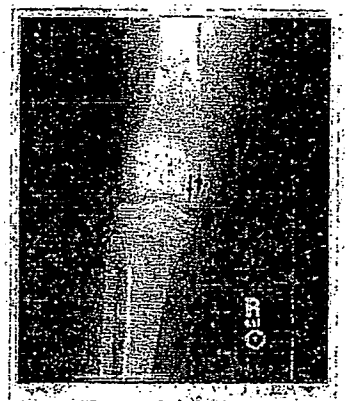
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Avascular necrosis usually affects people between 30 and 50 years of age; about 10,000 to 20,000 people develop avascular necrosis of the head of the femur in the US each year. When it occurs in children at the femoral head, it is known as Legg-Calvé-Perthes syndrome.[19]

Diagnosis

Orthopaedic doctors most often diagnose the disease except when it affects the jaws, when it is usually diagnosed and treated by dental and maxillofacial surgeons.

Because in the early stage of the disease x-ray images usually appear normal, bone scintigraphy[20] and MRI[21] are the diagnostic modalities of choice. Both modalities can detect minimal changes at early stages of the disease. Late radiographic signs include a radiolucency area following the collapse of subchondral bone (crescent sign) and ringed regions of radiodensity resulting from saponification and calcification of marrow fat following medullary infarcts.



Front X-ray of right knee of an adolescent (epiphyseal plates are open): arrows point to avascular necrosis and developing osteochondritis dissecans in the outer medial condyle of femur

Treatment

Avascular necrosis is especially common in the hip joint. A variety of methods are now used to treat avascular necrosis,[18] the most common being the total hip replacement, or THR. However, THRs have a number of downsides including long recovery times and short life spans. THRs are an effective means of treatment in the geriatric population, however doctors shy away from using them in younger patients due to the reasons above. A new, more promising treatment is hip resurfacing or metal on metal (MOM) resurfacing. It is a form of a THR, however in this procedure, only the head of the femur is removed as opposed to a THR in which the entire neck is removed. MOM resurfacing is still experimental in America but has been endorsed in Great Britain as an excellent alternative to a THR. A MOM Resurfacing may not be suitable in all cases of Avascular Necrosis, its suitability depends on how much damage has occurred to the femoral head of the patient, bone is always undergoing change or remodelling.[22] The bone is broken down by osteoclasts and rebuilt by osteoblasts.[22] Some doctors also prescribe bisphosphonates (e.g. alendronate) which reduces the rate of bone breakdown by osteoclasts, thus preventing collapse (specifically of the hip) due to AVN.[23]

Other treatments include Core Decompression, where internal bone pressure is relieved by drilling a hole into the bone, and living bone chip and electrical device to stimulate new vascular growth are implanted; and the Free Vascular Fibular Graft (FVFG), in which a portion of the fibula, along with its blood supply, is removed and transplanted into the femoral head.[24]

Progression of the disease could possibly be halted by transplanting nucleated cells from bone marrow into avascular necrosis lesions after core decompression, although much further research is needed to establish this technique.[25]

Prognosis

The amount of disability that results from avascular necrosis depends on what part of the bone is

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affected, how large an area is involved, and how effectively the bone rebuilds itself. The process of bone rebuilding takes place after an injury as well as during normal growth.[22] Normally, bone continuously breaks down and rebuilds—old bone is reabsorbed and replaced with new bone. The process keeps the skeleton strong and helps it to maintain a balance of minerals.[22] In the course of avascular necrosis, however, the healing process is usually ineffective and the bone tissues break down faster than the body can repair them. If left untreated, the disease progresses, the bone collapses,[1] and the joint surface breaks down,[12] leading to pain and arthritis.[12]

Notable individuals affected

Avascular necrosis cut short the football and baseball careers of star athlete Bo Jackson.[26]

Other sports stars with this condition are former NFL running back Garrison Hearst, cyclist Floyd Landis, NFL quarterback Brett Favre, professional wrestler "Superstar" Billy Graham, wrestler Joe Heat, Number one draft pick for the Minnesota Lynx: Ben Dvorak, NBA player Jorge Garbajosa, and gymnast Jade Barbosa.

In addition to the athletes listed, AVN has affected Edward Van Halen, lead guitarist for the rock band Van Halen, and Micky Dolenz, the drummer/singer of the band The Monkees.

See also

Dysbaric osteonecrosis

References

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External links

- Osteonecrosis / Avascular Necrosis at the National Institute of Health
- Osteonecrosis / Avascular necrosis at Merck Manual for patients
- Osteonecrosis / Avascular necrosis at Merck Manual for medical professionals
- Femoral head avascular necrosis at eMedicine
- Center for Osteonecrosis Research
- National Osteonecrosis Foundation
- Avascular Necrosis Resources

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Categories: Skeletal disorders | Diving medicine

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PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

RECEIVED
OCT 27 2009
PENSACOLA DISABILITY CLAIMS

MAIL CENTER
OCT 27 2009
PENSACOLA

MIKE RUSSELL

2

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home Cell ~~Work~~	Age: 37
Claim No: 02-001-001-080900062	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Dedmond- Lexington Orthopedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report? Dr. Odom Aug. 25
Dr. Dedmond Aug. 26
Dr. Suarez Sept. 29

4. Have you been confined to a hospital since completing your last report? Yes (If "YES", give date of confinement and attach a copy of your hospital bill.) have not received bill yet
Hospital Lexington medical Center
Address West Columbia, SC 29169
Admitted: 10-5-09 Discharged 10-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☑ YES, I have been confined to the house since completing my last report.
☐ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

resting, watching TV, completing exercises, reading, etc.

DATE: 10-21-09 SIGNED: Mike Russell

ADDRESS: 14169 Dogwood Rd. West Columbia, SC 29172

C-3 R

Rev. 4-97

PLIC 0153

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	733.42
2. Describe any other conditions contributing to present disability.	NA
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report: 10-26-09 Dr. Dellon 9/29/09 - Dr. Suarez 10/5/09 - Dr. Suarez (Surgery) 10-29-09 Suarez
3a Next Appointment Date:	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital: Lexington Medical Center Address: 2720 Sunset Blvd Admitted: 10-5-09 Discharged: 10-8-09
5. When did or will your patient be able to resume some work or activity?	Approx: 1-5-10
6. When did or will your patient be able to resume full work?	Approx 1-5-10
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	[ ] YES [X] NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

Lexington Orthopaedics
146 N. Hospital Drive, Ste.140
West Columbia, SC 29169
(803) 936-7230

DATE: 10-20-09 SIGNED: [signature]

ADDRESS: TELEPHONE

C-3 R

Rev. 3-96

PLIC 0154

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PLIC 0155

Russell

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PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

Bill Maloney
925 Southwest 150 Terrace
Ft. Lauderdale, FL 33326



PLIC 0156

Field Referral

Insured: Mike Russell	Today's Date: October 9, 2009
Dependent:	Benefits Paid to: 08/25/09
Policy No.: [redacted]9360	Adjustor: Ella Lee
Address:	Line of Business: ☒ A&H ☐ MILICO ☐ II ☐ LIFE
City: State: Zip:	Incurred Date: 06/18/08
Attorney Name:	**FOR FIELD SERVICES / TCR USE**
Address:	TCR Name: Bill Maloney
City: State: Zip:	Date Mailed: 10/09/09
Directions:	Date of Contact:

INSTRUCTIONS

Can you please visit the above insured. He is a 35 year old construction worker who was in a motorcycle accident. Please see if he has returned to work and when. If he has not returned to work, please find out when he plans on returning. Also please obtain a signature so that I can request a 1120 business tax form and a signed HIPAA Authorization. Obtain all of the doctors he is seeing for his current condition. Any other pertinent information.

REPORT OF CONTACT

Dictation Date: _____

Dictation Tape No.: _____

TCR: _____

Pennsylvania Life Insurance Company
www.pennlife.com

HIPAA Authorization Addendum

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB Group, Inc., employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Pennsylvania Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's " Notice of Privacy Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to The Company's Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke is also subject to the rights of The Company under any law granting The Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Patient's Name:

Mike		Russell
First	Middle	Last

Other Names Used:

Date of Birth: [redacted]

Social Security Number: [redacted]

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18)

Date:

Signature of Spouse:
(If applying for coverage)

Date:

Signature of Authorized Representative:

Relationship:

Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AA-0403

PLIC 0158

NOTICE TO PERSONS PROPOSED FOR INSURANCE

As part of our normal procedure for processing your application, an investigative consumer report, including driving records and credit reports, may be obtained. (In WV, no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance.). In accordance with the Federal Fair Credit Reporting Act (FCRA) you may obtain a copy of such report by writing The Company.

In addition we may contact you to schedule and conduct a personal interview with the proposed insured(s) to ask specific questions related to the qualifications for coverage or benefits under the proposed insurance.

Within a reasonable time after the receipt of this Notice, you have the right to make a written request of The Company to receive additional information about the nature and scope of any investigation The Company conducted.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P. O. Box 105 Essex Station, Boston, MA 02112, telephone number 617-426-3660. The Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

Pennsylvania Life Insurance Company

Form **4506**
(Rev. October 2008)
Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ Do not sign this form unless all applicable lines have been completed.
Read the instructions on page 2.
▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
Mike Russell	[redacted]
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.

Pennsylvania Life Insurance, P.O. Box 12355, Pensacola, FL 32591, ATTN: Ella Lee, 888-399-8847, extension 2492.

Caution: *DO NOT SIGN this form if a third party requires you to complete Form 4506, and lines 6 and 7 are blank.*

6 **Tax return requested.** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1120
Note. *If the copies must be certified for court or administrative proceedings, check here.* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

12 / 31 / 07	/ /	/ /	/ /
12 / 31 / 08	/ /	/ /	/ /

8 **Fee.** There is a $57 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	$ 57.00
b Number of returns requested on line 7	2
c Total cost. Multiply line 8a by line 8b	$ 114.00

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here	▶ Signature (see instructions)	Date
	▶ Title (if line 1a above is a corporation, partnership, estate, or trust)	
	▶ Spouse's signature	Date

Telephone number of taxpayer on line 1a or 2a
( )

PLIC 0160

General Instructions

Section references are to the Internal Revenue Code.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate a third party to receive the tax return. See line 5.

How long will it take? It may take up to 60 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year and the chart below shows two different RAIVS teams, send your request to the team based on the address of your most recent return.

Note. *You can also call 1-800-829-1040 to request a transcript or get more information.*

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to the "Internal Revenue Service" at:
District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, Vermont	RAIVS Team Stop 679 Andover, MA 05501
Alabama, Delaware, Florida, Georgia, North Carolina, Rhode Island, South Carolina, Virginia	RAIVS Team P.O. Box 47-421 Stop 91 Doraville, GA 30362
Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	RAIVS Team Stop 37106 Fresno, CA 93888
Arkansas, Connecticut, Illinois, Indiana, Michigan, Missouri, New Jersey, Ohio, Pennsylvania, West Virginia	RAIVS Team Stop 6705-S-2 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to the "Internal Revenue Service" at:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Utah, Washington, Wyoming, a foreign country, or A.P.O. or F.P.O. address	RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin	RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 60 days of the date signed by the taxpayer or it will be rejected.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the Letters Testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. Sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form, 10 min.; Preparing the form, 16 min.; and Copying, assembling, and sending the form to the IRS, 20 min.**

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Do not send the form to this address. Instead, see *Where to file* on this page.

Form 4506, Request for Copy of Tax Return

Individual taxpayers who, at the time the return was filed, resided in the District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New York, or Vermont must:

- Mail Form 4506 to ***Internal Revenue Service, RAIVS Team, Stop 37106, Fresno, CA 93888.***

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310361735	10/09/09	4210035890	$******2,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100*

To The Order Of MIKE RUSSELL
T

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210035890
CHECK DATE 10/09/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 10-09-09
CLAIM NO. 0809-00062 REF ID. BD310361735

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-09	08-25-09	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-09	08-25-09	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		38,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0163

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 10/9/09

Rvs

CLAIM NUMBER: 0809-00002

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER | L | REVIEW DATE | PAY TYPE: B

CSIE	CNCO	DATE INCURRED
SEE CLAIM NUMBER		CHANGE TO:

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted] 9360	0120	8090			✓							D

RI	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	DR
2	12		072509	082509			
4	12		072509	082509			

MANUAL DRAFT NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0164

PENNSYLVANIA LIFE INSURANCE COMPANY
P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
SEP 28 2009
PENSACOLA

MIKE RUSSELL

72

Dependent Name

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 02-001-001-080900062
	Home	803-955-0329		
cell	~~Work~~	803-513-0575	37	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident- broken leg and hip
2. What is the name and address of all physicians currently treating you?
   Dr. Odom PO Box 1997 Irmo, SC 29063
   Dr. Suarez + Dr. Desmond - Lexington Orthopedic 140 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   Dr. Odom - Aug. 25
   Dr. Desmond + Suarez Aug. 26
4. Have you been confined to a hospital since completing your last report? NO
   (If "YES", give date of confinement and attach a copy of your hospital bill.)
   Hospital
   Address
   Admitted: Discharged
5. Have you performed any work or activities since completing your last report?
   ☐ YES ☑ NO
6. If "YES", please describe the type of work or activities performed and when this first began.
   Describe work or activities:
   Date these duties first performed:
   RECEIVED SEP 28 2009 PENSACOLA DISABILITY CLAIMS
7. When do you expect to begin working at all of your duties?
   unknown
8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
   ☐ YES, I have been confined to the house since completing my last report.
   ☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
resting, watching TV, completing exercises, reading, etc

DATE: 9-23-09 SIGNED: Mike Russell

ADDRESS: 1

C-3 R

Rev. 4-97

PLIC 0165

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80, 823.81 996.4	Closed fracture of tibia Closed fracture of fibula mechanical compl. of internal orthopaedic device
2. Describe any other conditions contributing to present disability: See above	
3. Describe dates of treatment since last report and indicate if patient is still under your care ~~Yes~~ 7/8/09 8/26/09	Dates of treatment since last report: 8/26/09, 7/8/09 &
3a Next Appointment Date: 9/29- Dr. Suarez 10/26/09- Dr. Dedmond	Patient discharged on: no
4. Has the patient been confined to a hospital since completing your last report? no (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? unable to determine -	re-eval on 10/26 with Dr. Dedmond - for leg surgery on 10/5/09 w/Dr. Suarez for hip
6. When did or will your patient be able to resume full work? unable to determine	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☐ YES ☒ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

patient being treated by Dr. Barnaby Dedmond for his left tibia/fibula fracture and will be evaluated and treated by Dr. Randall Suarez for his hip.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 9/18/09 SIGNED: BDell

ADDRESS: Lexington Orthopaedics
146 N. Hospital Drive
Suite 140
West Columbia, SC 29169

TELEPHONE 803-936-7230

C-3 R

Rev. 3-96

PLIC 0166

ROA 1909

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 SEP 24 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

PLIC 0167

PENNSYLVANIA LIFE INSURANCE CO.

September 21, 2009

Mike Russell

RE: Policy No: [redacted]9360
Claim No: 0809-00062

Dear Mr. Russell:

Your claim is currently being reviewed. Your policy requires that you submit regular proof of loss.

We have not received a completed claim form since your last benefit check was issued. You and your doctor need to complete the enclosed claim form and return it to this office as soon as possible.

If you have returned to work (or your normal daily activities, if not employed) please provide us with the date.

Thank you for your cooperation. If you have any questions, please contact this office at 1-888-399-8847, extension 2492.

Sincerely,

Ella Lee
Disability Claims Advisor
Claims Department

cc: File

PO Box 12355, Pensacola, FL 32591 • (Tel) 1-888-399-8847 (Fax) 1-850-432-6077

Stacey

U.S. Claims Check Request

Pennsylvania Life Insurance Company (US) (0101)

Issue Check To: HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875

Date: August 24, 2009
Amount: $47.92
Ordered By: Ella Lee

Tax ID Number: [redacted]
Invoice Number: 0059139080
Insured: Mike Russell

Approved By:
Date Approved:

	Account #	Budget	Amount	Claim #	Policy #
1	7011305		$47.92	0809-00062	[redacted]9360
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
Total Check Disbursement			$47.92		

9-4-09
Ella

Special Instructions

Please mail attached letter with check ☐

Please return check ☒

COMPLETED mc 9/2/09

Claim File Location

Account # Ledger

7011301 - Inspection Reports, Investigations, Surveillance
7011302 - IME, FCE, TSA, LMS, COD
7011305 - Medical Records, WCB Reports

PLIC 0169

HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875
Fed Tax ID 58 - 2659941
(770) 754 - 6000

HealthPort
INVOICE

Invoice #: 0059139080
Date: 7/28/2009
Customer #: 1445806

Ship to:
ELLA LEE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 12355
PENSACOLA, FL 32591

Bill to:
ELLA LEE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 12355
PENSACOLA, FL 32591

Records from:
LEXINGTON MEDICAL CENTER
ATTN: LINDA GRIMES
2720 SUNSET BLVD
LEXINGTON, SC 29169

Requested By: PENNSYLVANIA LIFE INSURANCE
Patient Name: RUSSELL MIKE
SSN: *****7773
DOB: [redacted]

Description	Quantity	Unit Price	Amount
Basic Fee			15.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	15	0.50	7.50
Per Page Copy (Paper) 2	30	0.65	19.50
Shipping/Handling			2.58
Subtotal			44.58
Sales Tax			3.34
Invoice Total			47.92
Balance Due			47.92

Pay your invoice online at www.HealthPortPay.com

Terms: Net 30 days

Please remit this amount : $ 47.92 (USD)

HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875
Fed Tax ID 58 - 2659941
(770) 754 - 6000

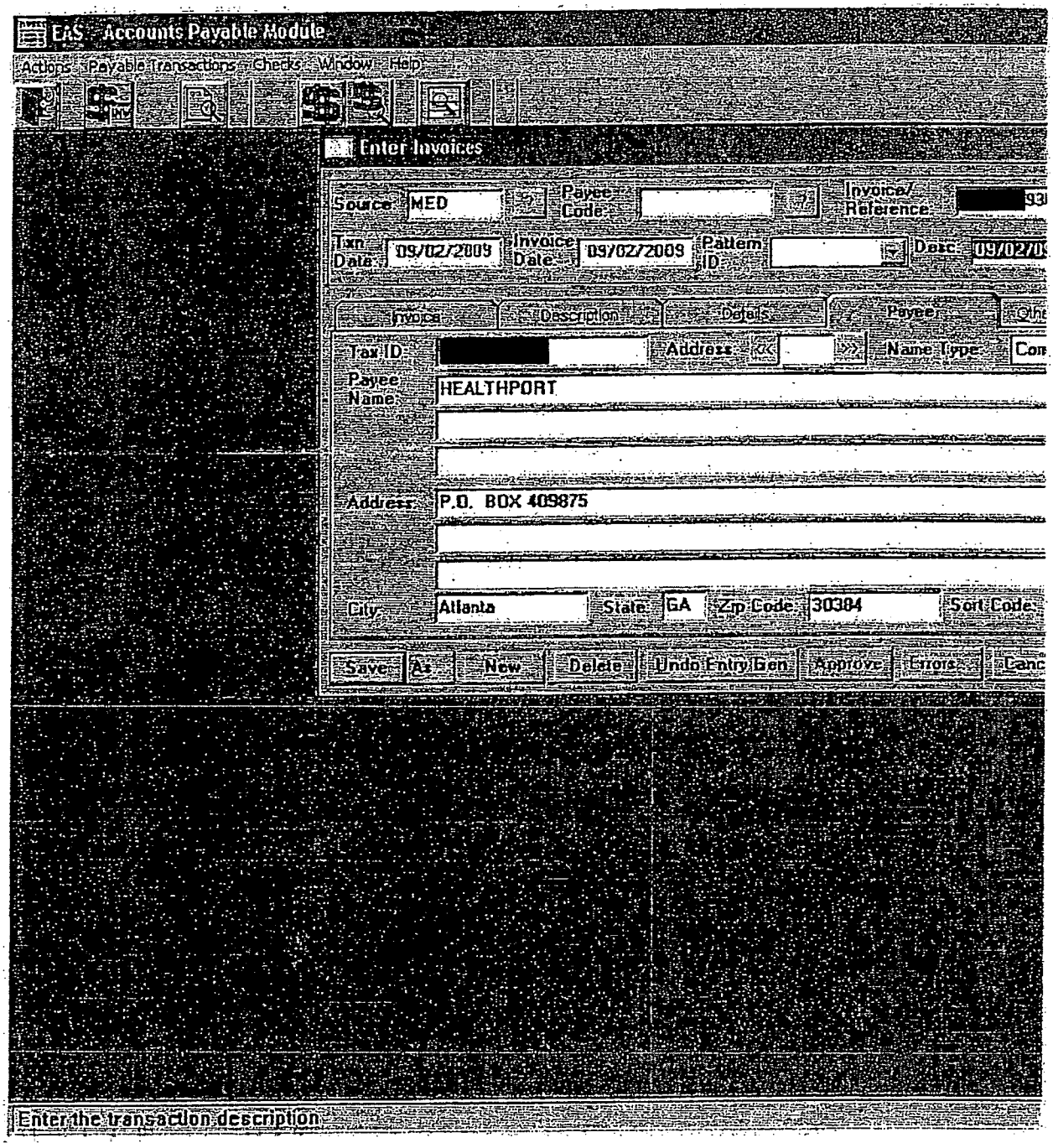
Invoice #: 0059139080

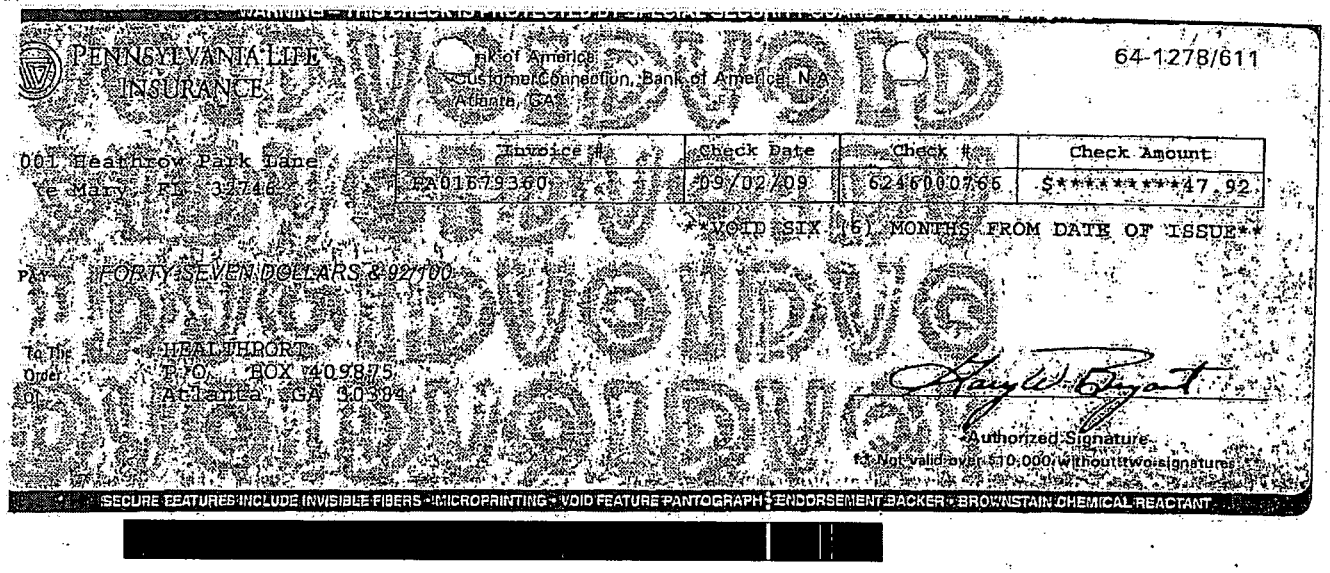
Check # _____

Payment Amount $_____

Please return stub with payment.
Please include invoice number on check.
To pay invoice online, please go to www.HealthPortPay.com or call (770) 754 6000.

PLIC 0170


EAS - Accounts Payable Module
Actions Payable Transactions Checks Window Help
Enter Invoices
Source: MED
Payee Code:
Invoice/ Reference:
Txn Date: 09/02/2009
Invoice Date: 09/02/2009
Pattern ID:
Invoice
Description
Details
Payee
Tax ID:
Address
Name Type:
Payee Name: HEALTHPORT
Address: P.O. BOX 409875
City: Atlanta
State: GA
Zip Code: 30384
Sort Code:
Save
New
Delete
Undo Entry/Ben
Approve
Errors
Enter the transaction description



PENNSYLVANIA LIFE INSURANCE

Bank of America
Customer Connection, Bank of America, N.A.
Atlanta, GA

64-1278/611

001 Heathrow Park Lane
Lake Mary, FL 32746

Invoice #	Check Date	Check #	Check Amount
[redacted]9360	09/02/09	6246000766	$*********47.92

VOID SIX (6) MONTHS FROM DATE OF ISSUE

Pay FORTY-SEVEN DOLLARS & 92/100

To the Order Of HEALTHPORT
P.O. BOX 740875
Atlanta, GA 30374

Authorized Signature
Not valid over $10,000 without two signatures

SECURE FEATURES INCLUDE INVISIBLE FIBERS - MICROPRINTING - VOID FEATURE PANTOGRAPH - ENDORSEMENT BACKER - BROWNSTAIN CHEMICAL REACTANT

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

HEALTHPORT
SOURCE-CODE MED

CHECK NUMBER 6246000766
CHECK DATE 09/02/09

Ref. Date	Invoice #	Description	Check Amount
09/02/09	[redacted]9360	[redacted]9360 Medical Records Request	47.92

PLIC 0172

Advisor: Ella Lee
Claim #: 0809-00062
Date: August 24, 2009

APP ROVAL(S) NEEDED

- [x] Over Limit
- [ ] Denial (Please have denial letter in file)
- [ ] IME Date of Last IME:
- [ ] FCE, [ ] VOC EVAL, and/or [ ] TSA Date of last:
- [ ] MED Recs Invoice over $100
- [ ] Surveillance From/To Dates:
- [ ] TCR Referral
- [ ] MRI
- [ ] Reopen (Summary should be attached)
- [ ] L-Card Placement (Summary should be attached)
- [ ] Contestable
- [x] Other (Please specify): letter approval

Question:

Advisor Opinion: Also over the limit. Sending med records to Dr. Nye after review is done.

Reviewer recommendations:

PENNSYLVANIA LIFE INSURANCE CO.

August 27, 2009

Mike Russell

RE: Policy No: [redacted]9360
Claim No: 0809-00062

Dear Mr. Russell:

We have completed our review of your claim.

You will soon receive benefits payable for your disability benefits from 05/25/09 to 07/25/09.

In addition, your policy also pays for the largest applicable amount for any one surgery due to an accident. We previously paid for a surgery performed on 06/24/08 for the surgery of your tibia fracture due to your accident on 06/18/08 in the amount of $3,000. The nonunion of your tibia procedure performed on 05/08/09 had a total amount of $1,250.00.

The largest applicable amount has been paid; therefore, no other benefits for surgery are due.

If you have any questions, please contact this office at 1-888-399-8847, extension 2492.

Sincerely,

CC 8/29/09

Ella Lee
Disability Claims Advisor
Claims Department

PO Box 12355, Pensacola, FL 32591 • (Tel) 1-888-399-8847 (Fax) 1-850-432-6077

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Reference #	Check Date	Check #	Check Amount
BD310358990	09/08/09	4210033163	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE AC

CHECK NUMBER 4210033163
CHECK DATE 09/08/09

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 09-08-09
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310358990

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-09	07-25-09	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-09	07-25-09	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	35,625.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0175

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Miller Russell

DATE: 08/24/04

RJS

CLAIM NUMBER: 0809-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L | REVIEW DATE | PAY TYPE
08/09 | B

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED: 06/18/08
CHANGE TO:

CC

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted] 9360	0120	8090	5010			✓						D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
			052509	072509			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0176

U.S. Claims Check Request

Pennsylvania Life Insurance Company (US) (0101)

Issue Check To: HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875

Date: August 24, 2009
Amount: $47.92
Ordered By: Ella Lee

Tax ID Number: [redacted]
Invoice Number: 0059139080
Insured: Mike Russell

Approved By:
Date Approved:

	Account #	Budget	Amount	Claim #	Policy #
1	7011305		$47.92	0809-00062	[redacted]9360
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
Total Check Disbursement			$47.92		

Special Instructions

Please mail attached letter with check ☐

Please return check ☒

Claim File Location

Account # Ledger

7011301 - Inspection Reports, Investigations, Surveillance
7011302 - IME, FCE, TSA, LMS, COD
7011305 - Medical Records, WCB Reports

PLIC 0177

8090

4 pgs 000638
**********AUTO**MIXED ADC 300
000000638 02 MB 0.895
ATTN: ELLA LEE
PENNSYLVANIA LIFE INSURANCE
PO BOX 12355
PENSACOLA FL 32591-2355

RECEIVED
AUG 24 2009
PENSACOLA DISABILITY CLAIMS

000400638G0

ATTENTION

Confidential information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
Please call the phone number on the enclosed invoice

Health Information is reproduced by HealthPort, a health information outsourcing service. Your healthcare facility contracts with HealthPort to process authorized copies of medical records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

PLIC 0178

HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Date
8/17/2009
Request ID #
0059810791

Ship to:

ELLA LEE
PENNSYLVANIA LIFE INSURANCE
PO BOX 12355
PENSACOLA, FL 32591-2355

Requested By: PENNSYLVANIA LIFE INSURANCE
Patient Name: RUSSELL MIKE
DOB: [redacted]
SSN: *****7773

Records from:

PALMETTO RICHLAND HOSPITAL
5 RICHLAND MEDICAL PARK
COLUMBIA, SC 29203

This is **NOT** a bill !

HealthPort
P.O Box 1813
Alpharetta, GA 30023-1812
Attn: Marketing

HealthPort processes thousands of requests for health information at over 6,500 health care facilities nationwide. If you would like to learn more about HealthPort, or how our suite of services can benefit your facility, please visit our website at: www.HealthPort.com or email us at: marketing@HealthPort.com

Your Name _____

Title _____

Facility Name _____

Phone Number (____) _____

Address _____

_____

City _____ State ____ Zip _____

# of Physicians _____ Specialty _____

# of Beds _____ # of Admits _____

PLIC 0179

PENNSYLVANIA LIFE INSURANCE CO.

[redacted]

May 15, 2009

Palmetto Health Richland
5 Richland Medical Park Dr.
Columbia, SC 29203
ATTENTION: Medical Records

RE: Patient: Mike Russell
Date of Birth: [redacted]
Social Security No: [redacted]
Policy No: [redacted]9360
Claim No: 0809-00062

Dear Sir or Madam:

In order to evaluate your patient's benefit eligibility, please provide the following information:

Diagnostic Test Results	Date: 06/18/08
Emergency Room Records	Date: 06/18/08
Toxicology Report	Date: 06/18/08

An authorization is enclosed for your records. If there is a fee for this service, please submit a statement with your response. Be sure to include your **Tax Identification Number.** If there is a pre-payment requested for these services, please fax your request to 1-850-432-6077.

We appreciate your cooperation. If you have any questions, please contact this office at 1-888-399-8847, ext. 2492.

Sincerely,

Ella Lee
Disability Claims Advisor
Claims Department

RECEIVED
JUL 27 2009

PLIC 0180

Date: 8/17/2009

To: Pennsylvania Life Insurance Co
P O Box 12355
Pensacola, FL 32533

From: Health Information Management Department
Palmetto Richland Hospital
5 Richland Medical Park
Columbia, SC 29203

Re: No Dates of Treatment as Requested
Medical Records Request for Mike Russell

Ref #:

We are unable to comply with your request at this time for the following reason(s):

We show no treatment at this facility for the dates of service you requested.

Please re-submit your request with the necessary information.

Thank you,

Health Information Management Department

PLIC 0181

0040

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MAIL CENTER
AUG 13 2009
PENSACOLA

MIKE RUSSELL

72

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 37	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No. [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Irmo, SC 29063
Dr. Suarez + Dr. Desmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom June 25
Dr. Desmond July 8

4. Have you been confined to a hospital since completing your last report? (If "YES", give date of confinement and attach a copy of your hospital bill.)
Out patient surgery - exchange nailing (D) Tibia w/ Fibular osteotomy
Hospital Lexington Medical Center
Address West Columbia, SC 29169
Admitted: 5-8-09 Discharged 5-8-09

5. Have you performed any work or activities since completing your last report?
☐ YES ☑ NO

6. If "YES", please describe the type of work or activities performed and when this first began.
Describe work or activities:
Date these duties first performed:

7. When do you expect to begin working at all of your duties?
Unknown

8. Have you been confined to the house since completing your last report? (See definition of CONFINEMENT below.)
☐ YES, I have been confined to the house since completing my last report.
☑ NO, I have not been confined to the house since:

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Resting, Watching TV, completing exercises, reading, etc.

DATE: 7-29-09 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0182

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 823.80 808.0	closed fracture unspecified tibia Acetabular Fracture
2. Describe any other conditions contributing to present disability.	
3. Describe dates of treatment since last report and indicate if patient is still under your care 5/8/09	Dates of treatment since last report:
3a Next Appointment Date: 8/26/09	Patient discharged on:
4. Has the patient been confined to a hospital since completing your last report? NO (If "YES", give date of confinement and attach a copy of your hospital bill.)	Hospital Address Admitted: Discharged
5. When did or will your patient be able to resume some work or activity? Unknown	
6. When did or will your patient be able to resume full work? Unknown	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.)	☒ YES ☐ NO

CONFINEMENT: Confinement is the inability to leave the house except to obtain medical treatment or engage in medically prescribed activities which are primarily therapeutic and not social, recreational or business in nature.

THIS SPACE FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Pt underwent surgery on 5/8/09 for a left tibial nonunion

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/09 SIGNED:

ADDRESS: 146 N. Hospital Dr. W. Columbia, SC 29169 TELEPHONE 803-936-7230

PLIC 0183

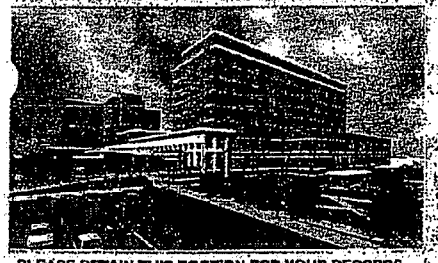
YOUR STATEMENT

Thank you for allowing us to serve your healthcare needs. We have received your payment. Please pay the balance in full or contact Customer Service for any questions regarding this bill.

10237-P555

SUMMARY OF CHARGES

250 PHARMACY GENERAL	502.00
258 PHARMACY IV SOLUTIONS	130.00
259 PHARMACY OTHER	10.25
270 M/S SUPPLY GENERAL	618.00
272 M/S SUPPLY STERILE SUPPLY	5866.11
278 M/S OTHER IMPLANTS	27716.50
300 LABORATORY GENERAL	13.00
302 LABORATORY IMMUNOLOGY	90.00
305 LAB HEMATOLOGY	226.00
306 LAB BACTERIOLOGY/MICROBIO	336.00
312 LAB PATHOLOGY HISTOLOGY	22.00
320 RADIOLOGY DIAG GENERAL	925.00
360 OR SVCS GENERAL	8021.00
370 ANESTHESIA GENERAL	1584.00
636 DRUG SPEC ID DETAIL CODING	24.00
710 RECOVERY ROOM GENERAL	1410.00
964 PROF FEES ANESTHET SP CRNA	3600.00
Billed charges to date:	51303.96



INSURANCE INFORMATION

BLUE CHOICE/COMPANION ZCL30241197

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803) 791-2000 OR (877) 855-6975, MONDAY-FRIDAY, 8:30 AM TO 5:30 P.M. SEE BACK FOR MORE INFORMATION.

ACCOUNT SUMMARY

Statement Date:	06/25/09
Patient Name:	MICHAEL C RUSSELL
Date of Service:	05/08/09
Account Number:	[redacted]
Total Charges:	51303.96
Insurance Payments Received:	-30141.91
Adjustments to Insurance:	-18643.63
Patient Payments Received:	-35.00

This is your balance: 2483.42

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

☐ Check box if below address is incorrect and indicate change(s) on reverse side.

LEXINGTON MEDICAL CENTER
2720 SUNSET BOULEVARD
WEST COLUMBIA, SC 29169

IF PAYING BY MASTERCARD OR VISA PLEASE, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT

☐ MASTERCARD ☐ VISA

CARD NUMBER	SIGNATURE CODE
SIGNATURE	EXP. DATE

DUE DATE	STATEMENT DATE	ACCT. #
07/10/2009	06/25/09	[redacted]

AMOUNT DUE	SHOW AMOUNT PAID HERE
2483.42	$

651741E

PAGE: 1 of 1

0101

MICHAEL C RUSSELL

[redacted]

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*TONOJI8BU000149

PLIC 0184

Russell

J 77

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.44⁰
0002797927 AUG 11 2009
MAILED FROM ZIP CODE 29204

PENNSYLVANIA LIFE
INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 1927

PLIC 0185

8890
0809- 00062

50 pgs 000651
**********AUTO**MIXED ADC 300
000000651 09 MB 2.085
ATTN: ELLA LEE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 12355
PENSACOLA FL 32591-2355

Mike Russell

RECEIVED
JUL 31 2009
PENSACOLA DISABILITY CLAIMS

00500006651G0X

ATTENTION

Confidential information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested,
Please call the phone number on the enclosed invoice

Health information is reproduced by HealthPort, a health information outsourcing service. Your healthcare facility contracts with HealthPort to process authorized copies of medical records.

Reproductions are made from the medical facility's original records. The confidentiality of these records is protected by federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

If you requested items that are not maintained in the medical record, your request for those items was forwarded to the appropriate department and will be sent under separate cover. Likewise, information that you asked to have delivered to another address is sent separately.

This package may or may not contain medical records, depending on what was requested and how it was processed.

PLIC 0186

HealthPort*Connect*

Why wait for medical records to be delivered when you can access them electronically as soon as they are available?

Conserve paper, save time and money with **HealthPort*Connect*!**

HealthPort*Connect* is a user-friendly, web-based interface that:

- Gives you instant online access to requested medical records
- Expedites medical records with electronic delivery
- Provides a safe, secure way to track and pay for medical records
- Eliminates shipping costs and saves on taxes *(where applicable*)*



It's Easy Going Green with HealthPort*Connect*!

Through our web portal, **HealthPort*Connect***, we electronically deliver over 45% of all requests for medical records to requesters, saving approximately 7,200 trees!

Follow these easy steps to sign up for automated release-of-information:

1. Go to **www.HealthPortConnect.com**
2. Click "More information..." in the blue box on the top right portion of the screen.
3. Follow the online instructions.
4. You will receive an information packet and membership form for **HealthPort*Connect*** via email. Please complete membership form and return via fax to 770-689-3208 or email it to Connect@HealthPort.com to initiate service.

Have Questions? Email us at Connect@HealthPort.com

Save Even More...

* You'll get additional sales tax savings if you are located in the following states:

Alabama | Arizona | California | Florida | Georgia | Michigan | Minnesota | Missouri
Nebraska | Pennsylvania | Tennessee

PLIC 0187

HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875
Fed Tax ID 58 - 2659941
(770) 754 - 6000

HealthPort
INVOICE

Invoice #: 0059139080
Date: 7/28/2009
Customer #: 1445806

Ship to:
ELLA LEE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 12355
PENSACOLA, FL 32591

Bill to:
ELLA LEE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 12355
PENSACOLA, FL 32591

Records from:
LEXINGTON MEDICAL CENTER
ATTN: LINDA GRIMES
2720 SUNSET BLVD
LEXINGTON, SC 29169

Requested By: PENNSYLVANIA LIFE INSURANCE
Patient Name: RUSSELL MIKE
SSN: *****7773
DOB: [redacted]

Description	Quantity	Unit Price	Amount
Basic Fee			15.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	15	0.50	7.50
Per Page Copy (Paper) 2	30	0.65	19.50
Shipping/Handling			2.58
Subtotal			44.58
Sales Tax			3.34
Invoice Total			47.92
Balance Due			47.92

Pay your invoice online at www.HealthPortPay.com

Terms: Net 30 days

Please remit this amount : $ 47.92 (USD)

HealthPort
P.O. Box 409875
Atlanta, GA 30384-9875
Fed Tax ID 58 - 2659941
(770) 754 - 6000

Invoice #: 0059139080

Check # _____

Payment Amount $_____

Please return stub with payment.
Please include invoice number on check.
To pay invoice online, please go to www.HealthPortPay.com or call (770) 754 6000.

PLIC 0188

PENNSYLVANIA LIFE INSURANCE CO.

May 15, 2009

[redacted]

Lexington Medical Center
2720 Sunset Blvd.
West Columbia, SC 29169
ATTENTION: Medical Records

RE: Patient: Mike Russell
Date of Birth: [redacted]
Social Security No: [redacted]
Policy No: [redacted]9360
Claim No: 0809-00062

Dear Sir or Madam:

In order to evaluate your patient's benefit eligibility, please provide the following information:

Diagnostic Test Results	Date: 06/18/08
Emergency Room Records	Date: 06/18/08
Toxicology Report	Date: 06/18/08

An authorization is enclosed for your records. If there is a fee for this service, please submit a statement with your response. Be sure to include your **Tax Identification Number.** If there is a pre-payment requested for these services, please fax your request to 1-850-432-6077.

We appreciate your cooperation. If you have any questions, please contact this office at 1-888-399-8847, ext. 2492.

Sincerely,

Ella Lee
Disability Claims Advisor
Claims Department

mail bill

PO Box 12355, Pensacola, FL 32591 • (Tel) 1-888-399-8847 (Fax) 1-850-432-6077

PLIC 0189

Pennsylvania Life Insurance Company
www.pennlife.com

8010

HIPAA Authorization Addendum

NOV 25 2008

PENSACOLA

This authorization is designed to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, MIB Group, Inc., employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to Pennsylvania Life Insurance Company (The Company) and its reinsurers, or its authorized representative, any and all such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, records of use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by The Company personnel to determine eligibility for life and/or health insurance and life and/or health insurance benefits. The Company may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. I further authorize The Company, and its reinsurers, to disclose information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. The information may be disclosed by The Company to MIB, who, upon request, may also disclose such information about you in its file to another member company with whom you apply for life or health insurance or to whom a claim for benefits may be submitted. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask The Company to correct, amend or delete any incorrect personal information. A copy of The Company's " Notice of Privacy Practices" is available upon request.

RECEIVED
NOV 26 2008
CIRCUIT COURT CLERK

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of revocation. This authorization may be revoked upon submission of a written notice to The Company's Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke is also subject to the rights of The Company under any law granting The Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Patient's Name:

Mike		Russell
First	Middle	Last

Other Names Used:

Date of Birth: [redacted]

Social Security Number: [redacted]

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18)

Date: 11-17-08

Signature of Spouse:
(If applying for coverage)

Date:

Signature of Authorized Representative:

Relationship:

Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AA-0403

PLIC 0190

Patient Fact Sheet

Name and Address
RUSSELL, MICHAEL C

Employer

Phone: (803)955-0329 Sex: M Phone:
SS No: [redacted] Marital Status M
Race: W Religion NO
BirthDate: [redacted] Occupation:
Patient's Maiden Name: DIANE

Nearest Relative

RUSSELL, SUSANNE

SC 29172
Home Phone: Rel: SPO
Business Phone:

RUSSELL, SUSANNE

SC 29172
Home Phone: Rel: SPO
Business Phone:
MCR LLC
1459 DOGWOOD ROAD
WEST COLUMBIA SC 29172
Home Phone: Rel:
Business Phone: (803)955-0329

Admission Data

Account Number	Unit Number
[redacted]	[redacted]

Admit Date	Admit Time	ER MD
6/18/2008	22:07	

Triage Time	Prim Care MD
	HALRIC EM, 01

Guarantor

RUSSELL, MICHAEL C

Home Phone (803)955-0329
Business Phone
Rel: SP SS: [redacted]
Occ:
Employer

Emergency Contact

RUSSELL, SUSANNE

Home Phone: Rel: SPO
Business Phone:

RUSSELL, SUSANNE

Home Phone: Rel: SPO
Business Phone:

PLIC 0191

Patient Fact Sheet

MCR LLC

Home Phone: Rel:

Business Phone: (803)955-0329

Insurance Information

Ins: BLUE CHOICE/COMPANION Insured: RUSSELL, SUSANNE C

Policy Number: [redacted] Group Number: Rel: SPO

P O BOX 6170

COLUMBIA SC 29260

Phone Number (803)786-8476 FIN HMO

Auth Number

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Record No. [redacted]

Date 6/18/2008

ID [redacted]

Lexington Medical Center

Emergency Department Record

History of Present Illness

TH

35 Year Old Male Patient Presents with leg pain left lower for 1 hour(s). The Onset is MVA (car vs motorcycle/moped) (S/P). The symptoms are Severe. Additional Symptoms or Pertinent History also involve OPEN TIB/FIB LEFT LOWER LEG AND ALSO C/O LEFT BUTTOCKS PAIN.; SLID INTO CAR LIKE SLIDING INTO A BASE .. Furthermore, the Patient/Family Denies other trauma.

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU Neg	Neuro	ENT Neg	Resp Neg	Musculoskeletal		Hematologic/Lymphatic Neg	
Skin	Psych Neg	Heart Neg	GI Neg	Endocrine Neg		Allergic/Immunologic Neg	
☐ All other ROS negative				Constitutional Sxs Neg		Eyes	

☑ Vital Signs/Triage/Nursing Notes Reviewed and Agree ☐ Hx unobtainable due to Tx urgency or poor historian(s) ☑ Additional Information from Police, Ambulance, Nursing Home or Relatives ☐ Old Medical Records Reviewed

Past Medical History ☑ No Relevant PMHx ☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA

Other PMHx ☐ Diabetes ☐ HTN ☐ Psychiatric ☐ Renal ☐ Seizures

Social History ☐ No Relevant SoHx ☑ ETOH ☐ Drugs ☑ Smoking Additional Sx

Family History

Physical Exam

Exam Time 22:17

TH

General Appearance	WD WN A&OIN PAINFUL DISTRESS
HEENT	NC/AT, PERRL, EOMI, MMM, Neck supple
Chest	RRR s MRG Lungs CTA s tachypnea Chest wall NT
Abdomen	Abd wall s hernias/abn findings Nl BS s bruits Soft, NT s HSM/mass
GU	PELVIS Stable to Rock
Extremities	Leg L Distal 1/3 Deformity-Severe DP 0 Decreased AROM (Severe) Tender - Severe
Neuro	
Skin	CLAMMY W & D
Back	NT,
Neck	NT, FROM, Thyroid benign, No JVD, No abnormalities noted
Lymphatics	

Repeat or Additional Clinical Notes

MD	Notes	Time
TH	FRACTURE REDUCED EMERGENTLY DUE TO NO PULSE AND DUSKY FOOT . REDUCTION MAINTAINED IN HARE TRACTION SPLINT. FOOT PINKED UP BUT STILL NO PULSE AT DP. ARTERIOGRAM ORDERED AND DR UDSON NOTIFIED. DR LEE CONSULTED FOR DEFINITIVE CARE	6/18/2008 10:58:00 PM
TH	DR LEE HAD CONCERNS ABOUT REPAIRING THE ACETABULAR FRACTURE AND REQUESTED CONSULTATION WITH PRMH AND DR MALOWAY THERE SAID WE SHOULD FIX THE TIB FIB AT LMC TONIGHT AND THEN DISCUSS A TRANSFER WITH THE TRAUMA ORTHOPEDIC SERVICE AT A LATER DATE	6/19/2008 12:30:00 AM
TH	LEFT FOOT DANGLING AND 10CM LACERATION OVER DISTAL ANT LAT TIB.. NO BONE PROTRUDING THROUGH LACERATION. LEG IS SHORTENED SEVERAL INCHES	6/19/2008 12:36:00 AM
TH	ABD REMANS SOFT AND NONTENDER AND NECK IS NONTENDER TO PALP AND ROM	6/19/2008 12:48:00 AM

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Reco[redacted]

Date 6/18/2008

TH	ARTERIOGRAM LEFT LEG WAS OKAY, SOME VASOSPASM AT FRACTURE SITE BUT VESSELS WERE NOT DISRUPTED. DR LEE INFORMED	6/19/2008 1:33:00 AM

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Record [redacted]

Date 6/18/2008

Diagnostics

Specimen Collected / ECG Rad Ordered

MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
TH	22:18	Tib-Fib L X-Ray	Fracture	TH	MIC	22:21
TH	22:18	Continuous Pulse Ox	Negative	TH	KDH	23:04
TH	22:18	Cardiac Monitor	Negative	TH	KDH	22:30
TH	22:47	Chest CxR PA Inspiration	No Acute Changes	TH	KDH	23:04
TH	22:47	Pelvis X-Ray	Acetabular Fx	TH	KDH	23:04
TH	22:47	Femur L X-Ray	ACETABULAR FR	TH	KDH	23:04
TH	22:48	CBC	WBC-14.7,HGB-13.8,HCT-39.3,PLT-266,NEUT-75,LYMP-16,EOS-1,MONO-8,BA-0,RBC-4.31,MCHC-35.0,MCV-91.2,RDW-13.0,ABA-0.00,AEOS-0.20,ALYMP-2.70,AMONO-0.90,ANEUT-10.90,	TH	MIC	23:41
TH	22:48	PT/PTT	PT-12.1,PTINR-0.9,PTT-20.7,	TH	MIC	23:41
TH	22:48	Chem 20/CMP	NA-142,K-4.6,CL-110,CO2-17,BUN-12,CREA-0.93,GLU-113,CA-8.0,AST-101,ALT-83,TP-6.9,ALKP-118,TBIL-0.5,DBIL-0.3,ALB-3.9,GGT-195,GFR->60,AGAP-15,	TH	MIC	23:41
TH	22:48	ETOH	ETOH-0.232,	TH	MIC	23:41
TH	22:48	EKG	No Acute Changes	TH	MIC	23:41
TH	22:58	Tib-Fib L X-Ray	GOOD REDUCTION	TH	MIC	23:11
TH	0:12	CT Hip L	DR LEE TO REVIEW	TH	MIC	2:11
TH	0:16	C-Spine Three Views	No Acute Changes	TH	MIC	0:26
TH	0:16	L-Spine X-Ray	No Acute Changes	TH	MIC	0:26
	0:40	Type and Screen	Pending	TH	MIC	0:57

Medical Orders

MD Initials	Time	Order	RN Initials	Time	Location-Response-Quantity	RN Remarks
SH	2:44	MORPHINE 4MG IV	MIC	2:44	RBVO DR. HALL	
TH	22:18	0.9NS 500ml Bolus	MIC	23:30	Finish Time - 00:36~	
TH	22:18	Ancef 1 gram IVPB	MIC	23:40	Finish Time - 00:36~	
TH	22:20	MOD	MIC	22:32		
TH	22:20	dT 0.5 ml IM	MIC	23:46	LOT #A002C EXP 01/07/2010, RT DELTOID	
TH	22:21	Propofol 40mg IV Dose @ Bedside (With Sedating MD @ Bedside)	KDH	23:04	Finish Time - -	
TH	22:23	CONSSENT FOR ORIF AND IRRIGATION AND DEBRIDEMENT LEFT TIBIA FRACTURE	MIC	23:11		
TH	23:54	ARTERIOGRAM LEFT LEG	MIC	0:35		
TH	0:27	MORPHINE 4-8MG IVP, INCREMENTS OF 4MG IVP	MIC	0:27	MORPHINE 4MG IVP @0034	
TH	1:38	D5.45NS @ 150ml/hr	MIC	2:29	Finish Time - 02:52-STILL INFUSING ON WAY TO OR	

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Record [redacted]

Date 6/18/2008

MD Procedures

Procedure Description

Time 0:43	MD TH	
Critical Care Time 31-74 minutes		99291 CPT
Time 0:45	MD TH	
Critical Care Time 75-104 minutes		99292 CPT
Time 0:45	MD TH	
Tibia (L) Fracture (Shaft) Closed Reduction & Immobilization Long Leg NV Intact INLINE TRACTION AND STABILIZED WITH HARE TX SPLINT.		
Time 0:47	MD TH	
IV Infusion (3 hr) for Therapy, Prophylaxis or Diagnosis, Therapy and Monitoring		90760, 90765,90766 CPT
Time 0:47	MD TH	
ECG Interpretation 12 Lead		93010 CPT
Time 0:47	MD TH	
Rhythm Strip Interpretation		93042 CPT
Time 0:47	MD TH	
Pulse Ox Interpretation		94760-26 CPT
Time 1:11	MD MN	
Conscious Sedation IV (Mod.) First 30 Min. Age >5 Yrs Another MD Performing Procedure, EM MD Sedation Monitor c N Pox & Cardiac Monitor, Post Exam WNL Now all -sedation		
Time 2:19	MD TH	
Continuous Pulse Ox		94762-26 CPT
Time 2:19	MD TH	
Cardiac Monitor		

Recommended LOS/CPT/ICD-9 Code

Physician's LOS = 5 99285-25

Nurse's LOS = 5 612 APC

Diagnoses

leg pain	729.5 ICD-9
OPEN FRACTURE LEFT LOWER LEG	
Tibia-Fibula Fracture	823.82 ICD-9
Acetabular Fracture	808.1 ICD-9
ETOH Intoxication	305.00 ICD-9

Notifications

MD Notified	Time Notified	MD Init
lee,david Discussed Relevant Hx Exam, Diagnostic Evaluation & Disposition-Agrees c Plan.	23:54	TH
MALOWAY, ORTHO PRMH Discussed Relevant Hx, Exam, Diagnostic Evaluation & Disposition-Agrees c Plan.	0:30	TH
lee,david Discussed Relevant Hx Exam, Diagnostic Evaluation & Disposition-Agrees c Plan.	1:39	TH

RN Notifications

MD Notified	Page Time	Num Pages	ResponseTime
lee,david	22:47	1	2257
lee,david	1:38	1	

	MD	MD Time		RN	RN Date/ Time	Admit to
Disposition	TH	0:40	Admit Operating Room	MIC	6/19/2008	lee,david 2:50

PLIC 0196

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Condition TH 0:40 Fair

Medical Recor [redacted]

Date 6/18/2008

Physician (Print) Hall, Thomas MD (TH)

Physician Signature

Primary RN (Print) Cohen, Michael A., RN (MIC)

Other Physicians

Hall, Thomas MD (TH)~Nowell, Mac MD (MN)~Hayes, Steven MD (SH)~

Other Nurses

Turner, Shannon M (SMT)~Mahan,Doug (RAD)~HALL, ANGELA (EDT)~Behr, Sharymarie~Hardison, Margaret L. (MLH)~McClinton, Margaret Elizebeth (MEM)~Creech, Kimberly A. (KAC)~Frick, Kimberly Hodge RN (KHF)~Hannon, Ashley N (ANH)~Rogers, Tracie Herron (THR)~Hamrick, Karen EDT (KSH)~Propp, William~

This chart has been electronically signed via the EmpowER software.

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Rec No. [redacted]

Date 6/18/2008

Lexington Medical Center

Emergency Department Nursing Notes and Vital Sign

TimeEntered: 6/18/2008 2:45 Vitals Taken By: MIC

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O **	Right		R	18	96%	No Pain @ this time
T	Left	85	L 114/82			
R						

PLIC 0198

Patient Name RUSSELL, MICHAEL Medical Record [redacted]

Account Number [redacted] Date 6/18/2008

Lexington Medical Center

Emergency Department Nursing Notes and Vital Sign

Nursing Notes

Time Note Entered		RN Initials	Note
6/18/2008	22:21	MIC	PT INVOLVED IN MVC, LEFT LOWER TIB/FIB OPEN FRACTURE, PAIN, +MS, NO PALPABLE PULSE, PT DENIES LOC;Gen App-Awake A&Ox3;Chest-RRR No M,Lungs CTA No Ret,Chest Wall NT;ABD-Tenderness-None,No Pulsating Masses,BS-NL/No Bruits;Extr-Appearance Normal,Throughout all,Tenderness-None,CBR < 3sec,Active ROM-Full,extremities;Extr-Bruised-Multiple;Extr-Deformity-Severe, PULSE ABSENT ON THE LEFT, PULSE AND CR <2 ON RIGHT;ROAD RASH TO LEFT FOREARM AND ELBOW, +CMS, PT ON CONTINUOUS PULSE OX, CARDIAC MONITOR
6/18/2008	22:25	MIC	PT TO X-RAY VIA STRETCHER
6/18/2008	22:32	MIC	PT SEDATED FOR REDUCTION AND APPLICATION OF HARE TRACTION SPLINT
6/18/2008	22:50	MIC	PT TO X-RAY VIA STRETCHER, MONITOR AND RN
6/18/2008	23:30	MIC	IV Forearm R 18 Gauge Angio Cath, LABS DRAWN AND SENT, LAB DRAW FOR SAMPLE TO BLOOD BANK,
6/18/2008	23:38	MIC	LABS DRAWN AND SENT, IV 16 GAUGE PER EMS LEFT ANTECUBITAL, 1000 CC BOLUS LEFT AC
6/18/2008	23:40	MIC	DRESSING APPLIED WITH BETADINE TO LEFT TIB/FIB OPEN WOUND, PT CONTINUES TO HAVE +SENSATION AND MOTOR
6/18/2008	23:46	MIC	PT MEDICATED WITH ANCEF 1 GM IV;PT MEDICATED WITH TD 0.5ML R DELTOID
6/18/2008	23:57	MIC	POLICE AT BEDSIDE
6/19/2008	0:09	MIC	PT RESTING COMFORTABLY AWAITING ARTERIOGRAM
6/19/2008	0:21	MIC	PT HAS +CMS LEFT FOOT, PT CONTINUES TO HAVE BLEEDING FROM LEFT LEG WOUND
6/19/2008	0:36	MIC	PT TO ARTERIOGRAM VIA STRETCHER, PT MEDICATED WITH MORPHINE 4MG IVP FOR PAIN PRIOR TO BEING TRANSPORTED TO ARTERIOGRAM
6/19/2008	1:51	MIC	PT BACK FROM ARTERIOGRAM, PT TO X-RAY VIA STRETCHER
6/19/2008	1:51	MIC	PT'S RIGHT GROIN WOUND, NO HEMATOMA NOTED, BLEEDING CONTROLLED, NO PAIN AT SITE
6/19/2008	2:05	MIC	RIGHT GROING DRESSING INTACT, NO HEMATOMA NOTED, BLEEDING CONTROLLED, NO PAIN AT SITE
6/19/2008	2:20	MIC	RIGHT GROING NO CHANGE FROM PREVIOUS REPORT
6/19/2008	2:30	MIC	PT UNABLE TO GET CT SCAN D/T HARE TRACTION SPLINT, DR. HALL AWARE
6/19/2008	2:35	MIC	NO CHANGE IN RIGHT GROIN DRESSING, NO HEMATOMA NOTED, BLEEDING CONTROLLED
6/19/2008	2:48	MIC	DR. LEE AWARE OF UNABLE TO DO CT OF HIP
6/19/2008	2:50	MIC	PT HAS +CMS IN LEFT FOOT
6/19/2008	2:51	MIC	PT TO BE TRANSPORTED TO OR VIA STRETCHER

Patient Name RUSSELL, MICHAEL

Account Number [redacted]

Medical Reco [redacted]

Date 6/18/2008

Lexington Medical Center

Emergency Department Nursing Notes and Vital Sign

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved
Skin Integrity, Impaired R/T TIB FIB OPEN FRACTURE	Wound Healing is Promoted	No

Primary RN (Print) Cohen, Michael A., RN (MIC)

PLIC 0200

Lexington Medical Center Tri[illegible]e

Category: 2 U[illegible]table

Arrival Date/Time	Triage Time	Waiting Rm Time	Exam Rm Time
6/18/2008 22:07	22:09		22:09

PCP Staff Status: Not on Staff
Family Physician: NAGEL,TERRY L,DO
Transported by: Ambulance
Mode: Stretcher
Police Dept: Custody: [illegible] Notification: Beat #:

Chief Complaint: ankle pain
Onset Time:
Location:

Associated Sxs / Pertinent History:
pt with motorcycle accident, no helmet. Pt with open fx to Lt lower extremity. Unable to palpate pedal pulse.

Past Medical History: Additional:

- [x] No Significant PMHx
- [ ] Asthma [ ] COPD [ ] CAD [ ] Cancer [ ] CHF [ ] CVA
- [ ] DM [ ] HTN [ ] Psych [ ] Renal [ ] Seizures [x] Substance Abuse

Medications:
- [ ] No Meds [ ] Unknown

Zantac

Allergies:
NKDA

Immunizations UTD? Not UTD
TB Hx, PPD Pos or Infectious Exposures? No
If yes to TB or Infectious question take precautions

Mental Status / Psychological Eval:
Alert Oriented

Lung Sounds:

	R	L
Clear	[ ]	[ ]
Diminished	[ ]	[ ]
Wheezes	[ ]	[ ]
Rales	[ ]	[ ]
Rhonchi	[ ]	[ ]
Retractions	[ ]	[ ]

Eyes:

	R	L
Equal	[ ]	[ ]
Reactive	[ ]	[ ]
Fixed	[ ]	[ ]
Constricted	[ ]	[ ]
Dilated	[ ]	[ ]
Cataract	[ ]	[ ]

Glasgow Coma Scale:

Eye	Spontaneous
Verbal	Oriented
Motor	Obeys
Total	15

OB/Gyn:
LNMP

G	P	Ab	Miscarriages
0	0	0	0

Skin:

Color	Normal
Temp	Normal
Moist	Normal

Extremities:
Pulses
Pulse Absent
ROM

Nutrition:

Domestic Violence Assessment:
Are you being hurt by someone you live with or who takes care of you?
Yes/No No
* Mandatory completion of Domestic Violence Referral.

Fall Risk Assessment:
Altered Mobility

Date: 2-21 **Time:** 22:09
Triage Nurse: Turner, Shannon M (SMT)
TriageII: SMT
TriageIII: MIC

Functional Dx Planning:

Daily Living	Independent
Living Conditions	Family
Going Home with	Family

Patient Name: RUSSELL,MICHAEL
Medical Record Number: [redacted]
Account Number: [redacted]
DOB: [redacted]
Age: 35 Years
Gender: Male

Vitals

Tem

Oral	97.1
Rectal	
Tympanic	

Pulse

Right	
Left	82

Respirations: 18

Blood Pressure

Right	
Left	120/82

Pulse Ox:
Weight (Kg: 85 Kg
Height: **Head Circumferenc:**
Pain Scal: Moderate 5 - 6

Assessing Pate(nt)'s Child's or Parent's Readiness to Learn

Primary Language	English
Assessed Disability	No Disability
Communication Barrier	[ ]
Language Translator	[ ]
Motivation Level	High
Knowledge Level	High
Comprehension Ability	High

- [ ] LWBS
- [ ] LW Completed Tx/ Eloped
- [ ] AMA
- [ ] AMA Refused
- [x] Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

PLIC 0201

Patient Name RUSSELL, MICHAEL

Medical Record [redacted]

Account Number [redacted]

6/18/2008

Emergency Department Pharmacy and Supply Charges

Interventions

Intervention Name	Comments	Charge Code
0.9NS 500ml Bolus	Finish Time - 00:36~	
Ancef 1 gram IVPB	Finish Time - 00:36~	
MOD		
dT 0.5 ml IM	LOT #A002C EXP 01/07/2010, RT DELTOID	
Propofol 40mg IV Dose @ Bedside (W	Finish Time - ~	
CONSSENT FOR ORIF AND IRRIGA		
ARTERIOGRAM LEFT LEG		
MORPHINE 4-8MG IVP, INCREMEN	MORPHINE 4MG IVP @0034	
D5 45NS @ 150ml/hr	Finish Time - 02:52~STILL INFUSING ON WAY TO OR	
MORPHINE 4MG IV	RBVO DR. HALL	

Diagnostics

Diagnostic Ordered	Charge Code
Continuous Pulse Ox	0
Cardiac Monitor	0
CBC	0
PT/PTT	0
ETOH	0
EKG	0

Nurse LOS 5 **612 APC** **Charge Code** 0

PLIC 0202

Lexington Medical Center

Medication Reconciliation

Patient Name RUSSELL, MICHAEL

Medical Record No. [redacted]

Account Number [redacted]

Date of ED Visit 6/18/2008

Allergies

NKDA

Home Medications

	Physician Order Continue Medication?
Zantac	YES NO

Medications Administered in the Emergency Department

Ancef 1 gram IVPB	YES NO
dT 0.5 ml IM	YES NO
Propofol 40mg IV Dose @ Bedside (With Sedating MD @ Bedside)	YES NO
MORPHINE 4-8MG IVP, INCREMENTS OF 4MG IVP	YES NO
MORPHINE 4MG IV	YES NO

Medication Prescription provided on Discharge

PLIC 0203

ADVISEMENT OF IMPLIED CONSENT RIGHTS

Subject's Name (Print) [redacted] Date of Birth [redacted]

Driver's License Number [redacted] State Licensed SC

DRIVING UNDER THE INFLUENCE ADVISEMENT

(A) Will test be video recorded? If answer is Yes, start here → ◆ Inform subject of video recording.
◆ Advise subject of Miranda rights.

If answer is No, start here → ◆ Inform subject of the type (breath, blood, urine) samples requested.

(B) Then read the following advisement to subject:

◆ You are under arrest for Driving Under the Influence (DUI), Section 56-5-2930, South Carolina Code of Laws 1976, as amended.
◆ The arresting officer has directed that samples be taken for alcohol and/or drug testing.
◆ The samples will be taken and tested according to Section 56-5-2950 and SLED policies.
◆ You do not have to take the tests or give the samples, but if you refuse to submit to the tests your privilege to drive in South Carolina must be suspended or denied for at least ninety (90) days and your refusal may be used against you in court.
◆ If you take the tests or give the samples and have an alcohol concentration of eight one-hundredths of one percent (0.08%) or more, you may instead be charged with Driving with an Unlawful Alcohol Concentration (DUAC), Section 56-5-2933.
◆ If you have an alcohol concentration of fifteen one-hundredths of one percent (0.15%) or more, your privilege to drive in South Carolina must be suspended for at least thirty (30) days.
◆ You have the right to have a qualified person of your own choosing conduct additional independent tests at your expense and the officer, upon request, must provide you affirmative assistance.
◆ You have the right to request an administrative hearing within thirty (30) days of the issuance of the notice of suspension.
◆ If you do not request an administrative hearing or if your suspension is upheld at the administrative hearing, you must enroll in an Alcohol and Drug Safety Action Program.

If applicable, perform the following procedures:

(C) Check subject's mouth and remove any foreign material. (Not required if a refusal has occurred.)
(D) Time stamp Breath Alcohol Analysis Test Report. (Not required if a refusal has occurred.)
(E) Observe subject for a minimum of twenty (20) minutes before collecting breath sample. (Not required if a refusal has occurred.
(F) Enter biographical data into BAC DataMaster. (Required for all tests, including refusals.)

FELONY DRIVING UNDER THE INFLUENCE ADVISEMENT

(B) Will test be video recorded? If answer is Yes, start here → ◆ Inform subject of video recording.
◆ Advise subject of Miranda rights.

If answer is No, start here → ◆ Inform subject of the type (breath, blood, urine) samples requested.

(B) Then read the following advisement to subject:

◆ You are under arrest for Felony Driving Under the Influence (Felony DUI), Section 56-5-2945, South Carolina Code of Laws 1976, as amended, or a law enforcement officer has probable cause to believe that you have violated this section.
◆ The officer has directed that samples be taken for alcohol and/or drug testing.
◆ The samples will be taken and tested according to Section 56-5-2950 and SLED policies.
◆ Pursuant to Section 56-5-2946, you must submit to either one or a combination of chemical tests for the purpose of determining the presence of alcohol, drugs, or a combination of alcohol and drugs.
◆ The refusal, obstruction, or opposition to testing pursuant to Section 56-5-2946 is evidence admissible at trial.
◆ If your tests or samples have an alcohol concentration of fifteen one-hundredths of one percent (0.15%) or more, your privilege to drive in South Carolina must be suspended for at least thirty (30) days.
◆ You have the right to have a qualified person of your own choosing conduct additional independent tests at your expense and the officer, upon request, must provide you affirmative assistance.
◆ You have the right to request an administrative hearing within thirty (30) days of the issuance of the notice of suspension.
◆ If you do not request an administrative hearing or if your suspension is upheld at the administrative hearing, you must enroll in an Alcohol and Drug Safety Action Program.

If applicable, perform the following procedures:

(C) Check subject's mouth and remove any foreign material.
(D) Time stamp Breath Alcohol Analysis Test Report.
(E) Observe subject for a minimum of twenty (20) minutes before collecting breath sample.
(F) Enter biographical data into BAC DataMaster.

Officer's Name (Print) [redacted]

Officer's Signature [redacted]

Subject's Signature (Refused Copy) [redacted]

Date [redacted] Time 2355

PLIC 0204

RUSSELL MICHAEL C
MRN#
D.O.B:
Sex:MALE Age:35 YEAR Race:CAUCASIAN
Baytown Prov. ER EMA
Room#:2)
DX:LEG INJURY Tech:VML
Dept:ER
Time:23:10:46 06/18/08
LEXINGTON MEDICAL CENTER
Vent. Rate:83
--Durations--
QRS: 104 ms
--Intervals--
PR : 144 ms
QT: 368 ms
QTc: 409 ms
QTd: 44 ms
--Axes--
P : 35 °
QRS: 53 °
T : 6 °
SINUS RHYTHM
T-wave changes in inferior leads
THESE MINOR CHANGES ARE OF EQUIVOCAL SIGNIFICANCE ONLY
CLEVELAND MEDICAL CENTER
Chest 10 mm/mV
Chest 25 mm/sec
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
STAGE II 60 Hz

PLIC 0205

Lexington Medical Center

1. I hereby consent to and authorize Lexington Medical Center and my physician to perform the following operation or procedure: Open Reduction Internal Fixation of Left Ankle
to be performed on (patient name) [illegible]
Dr.(s) _____ and/or other doctor(s) he/she may choose, under the direction of

2. I know that during the operation or procedure, sometimes an additional or different procedure is needed. I give my permission to the above-named physician and any other physicians and assistants he may choose to perform these procedures if needed.

3. I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the operation or procedure. I give permission to the physician to decide how much and what kind, with the exception of:
_____ None: ✓

4. I understand that blood and/or blood products may be needed before, during and/or after the operation or procedure. I understand the risks and the choices available. I (do) (do not) give my permission to the physician to use blood and/or blood products if necessary. I (have) (have not) made prior arrangements for autologous donation, which is the donation and storage of one's own blood for elective medical/surgical procedures.

5. I give the hospital permission to dispose any tissue recovered or amputated parts, if amputation is necessary, during the course of the operation or procedure. I give the hospital permission to, at their discretion, save for research purposes all or part of the blood and/or tissue normally discarded. I understand that saved blood and/or tissue, as well as associated clinical data, will not identify me in any way.

6. I give permission to allow my physician to take pictures of my body parts, if needed, during the operation or procedure.

7. My physician or his/her designee has explained to me my diagnosis, the nature of the procedure, the major risks involved, the potential benefits, the probability of success associated with the procedure, the prognosis if the procedure is not done, any alternatives or options, and the potential problems related to recuperation. I understand the explanation provided and no guarantee of results has been given to me. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I voluntarily give my consent to the above operation or procedure.

Witness: Cynthia Shroder
Signature: Susan E Purcell
Date: 6/19/08 Time: 0247 AM PM
Relationship to Patient: Wife

I have discussed with the patient his/her diagnosis, the nature of the procedure, the major risks, the benefits, the potential complications, the probability of success, the prognosis if the procedure is not carried out, any alternatives, the potential problems related to recuperation, and the possible use of sedation/anesthesia and blood/blood products. I have answered the patient's questions and obtained permission to proceed.

_____ _____
Physician Signature Date

For Surgical, Interventional or Invasive Diagnostic Procedure Use Only
Date: 6/19/08 Time: 0247 AM PM
Correct Patient ✓ Correct Site ✓
Correct Procedure ✓ Correct Side ✓
Correct Films ✓ Correct Position ✓
Correct implants/equipment, as applicable ✓
Clinical Verification by Surgical/Procedure Team
Physician [illegible] Anesthesia [illegible]
RN/Lead Tech [illegible]

Perioperative documentation of this process is in the electronic medical record.

Consent to Operation or Procedure Label

If the patient does not consent to the administration of blood or blood products, notify the physician in person as possible and have the patient sign the "Refusal of Treatment" form.

7181-541-1
6/08

Use Ball Point Pen

PHYSICIAN'S ORDERS

DATE	TIME	AM / PM	FAXED / SCANNED	INITIALS
6/15	1248			

Morphine 2mg IV q4hr prn pain

C.O: Dr Hudson MJ Hay RN

DATE	TIME	AM / PM	FAXED / SCANNED	INITIALS
6/15/07	0127			

Pt c/o pain 10/10 Dr Hugo notified pt will be given Morphine 2mg IV q4hr prn

DATE	TIME	AM / PM	FAXED / SCANNED	INITIALS

[redacted]

7070-012-1 (Rev 5/8/07) LEXINGTON MEDICAL CENTER Original: Chart

PLIC 0207

POST-PROCEDURE PROGRESS NOTE

Date/Time: [illegible]

Physician: [illegible] Scrub Tech: [illegible]

Nurse: [illegible] Rad. Tech: [illegible]

Procedure: [illegible]

Findings/Post-Procedure Diagnosis: [illegible]

Plan/Intervention: [illegible]

Outcome of Treatment: [illegible]

Complications: [illegible]

Contrast: [illegible] Total Contrast: [illegible]

Specimen: [illegible] EBL: [illegible]

Condition: ☒ Good ☐ Other [illegible]

Disposition: ☐ Transfer to Medical Day Care ☐ Admit ☐ Other [illegible]
☒ Return to Room ☐ Home

[illegible]
Physician Signature

[redacted]

RADIOLOGY SHORT STAY RECORD

PLIC 0208

LEXINGTON MEDICAL CENTER
PRE-PROCEDURE NOTE

Date/Time 6-19-08 0900

Present Illness/Pre-Procedure Diagnosis TIVC

History: Past Medical/Surgical History (pertinent) C

Non-Invasive Imaging: X-ray Pertinent Meds: Zosyn

LABS: PT 12.1 INR 0.1 PTT 27.7 Platelets 240

BUN 17 Creat 0.6 Fibrinogen Other

ALLERGIES: NKDA

PHYSICAL EXAMINATION: ☒ H&P reviewed

Heart: ☒ Normal ☐ Irregular rhythm

Lung: ☒ Normal ☐ Labored respirations ☐ Other

BP 124/64 Pulse Rate 92 Resp. Rate 18 O2 Sat 97% Temperature

EKG NSR

Physician Signature

Lexington Medical Center

1. I hereby consent to and authorize Lexington Medical Center and my physician to perform the following operation or procedure: Cervical Surgery
(C Fusion Fix or Revision)
to be performed on (patient name) [redacted], under the direction of Dr.(s) Hall and/or other doctor(s) he/she may choose.

2. I know that during the operation or procedure, sometimes an additional or different procedure is needed. I give my permission to the above-named physician and any other physicians and assistants he may choose to perform these procedures if needed.

3. I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the operation or procedure. I give permission to the physician to decide how much and what kind, with the exception of: None.

4. I understand that blood and/or blood products may be needed before, during and/or after the operation or procedure. I understand the risks and the choices available. I (do) (do not) give my permission to the physician to use blood and/or blood products if necessary. I (have) (have not) made prior arrangements for autologous donation, which is the donation and storage of one's own blood for elective medical/surgical procedures.

5. I give the hospital permission to dispose any tissue recovered or amputated parts, if amputation is necessary, during the course of the operation or procedure. I give the hospital permission to, at their discretion, save for research purposes all or part of the blood and/or tissue normally discarded. I understand that saved blood and/or tissue, as well as associated clinical data, will not identify me in any way.

6. I give permission to allow my physician to take pictures of my body parts, if needed, during the operation or procedure.

7. My physician or his/her designee has explained to me my diagnosis, the nature of the procedure, the major risks involved, the potential benefits, the probability of success associated with the procedure, the prognosis if the procedure is not done, any alternatives or options, and the potential problems related to recuperation. I understand the explanation provided and no guarantee of results has been given to me. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I voluntarily give my consent to the above operation or procedure.

Witness: [redacted] Signature: Suzanne C. Russell

Date: 6/16 Time: ____ AM PM Relationship to Patient: Wife

I have discussed with the patient his/her diagnosis, the nature of the procedure, the major risks, the benefits, the potential complications, the probability of success, the prognosis if the procedure is not carried out, any alternatives, the potential problems related to recuperation, and the possible use of sedation/anesthesia and blood/blood products. I have answered the patient's questions and obtained permission to proceed.

Physician Signature: [redacted] Date: 6/18/08

For Surgical, Interventional or Invasive Diagnostic Procedure Use Only

Date: 6/18 Time: 0730 AM PM

Correct Patient — Correct Site
Correct Procedure — Correct Side
Correct Time — Correct Position
Correct implants/equipment, as applicable

Consent Verification for Surgical Procedure Team

Physician: [redacted] Anesthesia: [redacted] RN: [redacted]
RN/LPN/Tech: [redacted]

Pre-operative documentation of this process is in the electronic medical record.

Consent to Operation or Procedure

If the patient does not consent to the administration of blood or blood products, notify the physician in addition to pass Testimonial" form.

3721-941-1
0808

[redacted] 06/16/08 35
RUSSELL, RICHARD, C
[redacted] HALL, FRANCIS, E, MD
[redacted]

PLIC 0210

ROA 1952

EKG SLIPS

V-RATE	A-RATE	PP	QRS	INTERPRETATION	NURSE'S SIGNATURE

22:06	120/ 82(97) mmHg	PR= 82	(NIBP)
22:31	103/ 81(89) mmHg	PR= 86	(ECG)
22:35	106/ 72(88) mmHg	PR= 87	(ECG)
22:40	118/ 84(93) mmHg	PR= 84	(ECG)
22:45	117/ 80(95) mmHg	PR= 89	(NIBP)

START

LAST BP=
23:29
06/18

NIBP

V-RATE	A-RATE	PR	QRS	INTERPRETATION	NURSE'S SIGNATURE

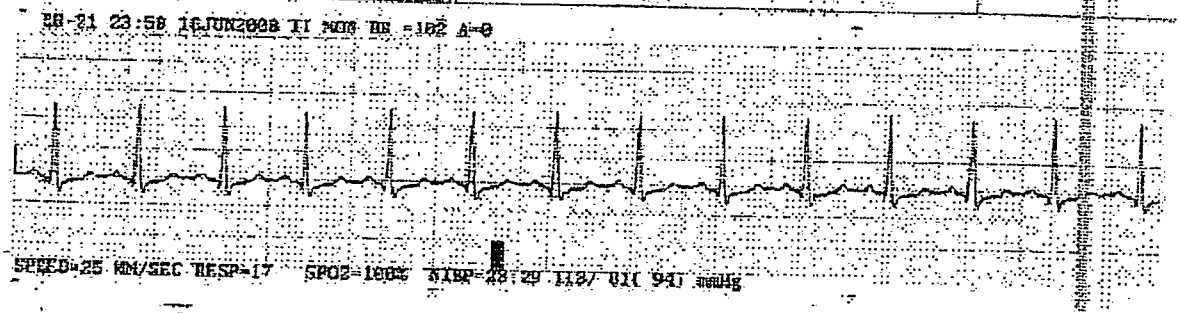
22:50	???		
22:56	???		
23:00	???		
23:12	97/ 80(87) mmHg	PR= 88	(ECG)
23:29	113/ 81(94) mmHg	PR= 86	(ECG)

START

LAST BP=
23:29
06/18

NIBP

V-RATE	A-RATE	PR	QRS	INTERPRETATION	NURSE'S SIGNATURE



[redacted] 06/14/06 35

[redacted]

[redacted]

LEXINGTON MEDICAL CENTER

PLIC 0211

LEXINGTON MEDICAL CENTER

As soon as the patient receives medications placing him/her in moderate sedation, he/she will be monitored continuously and have documentation every 5 minutes of BP, HR, RR, O_2 Sat & LOC. Post procedure, the patient's physiological status, mental status and pain level are monitored every 15 minutes until discharge criteria are met. (SEE BACK FOR DISCHARGE CRITERIA)

TIME	B/P	HR	RR	O_2Sat	LOC‡	PAIN SCALE	MEDICATION DOSE/ROUTE	NURSING INTERVENTIONS PATIENT RESPONSE
Baseline	144/80	84	16	95%	AOX3	10		IV insertion: Size 18 Site L hand
2232		84	18	93%	AOX3	10	Propofol 50 mg IVP	40 Propofol
2233		83		98%				Explained the procedure
2235	104/72	76	17	97%	Alert	10	Propofol 20 mg	Pt expressed fear of the procedure
2240	118/81	83	19	98%			Propofol 20 mg	
2245	117/80	77	18	98%	Sleepy			a.d. Begins MS
2250		74	16		AO	4/10		10 Versed
2255						5/10		Versed
2300					Alert	5/10		Versed
2305								None
2310	97/62	82	16	100%	AOX3			Safety measures
2315	113/68	85	16	97%	AOX3			Pt ready for D/C

Sedation / Anesthesia Plan: ☐ Minimal Sedation ☑ Moderate Sedation

Only for Moderate Sedation do you need to complete the remainder of the form

Sedation/Anesthesia History: ☑ None ☐ Sleep Apnea ☐ Previous problem sedation/anesthesia

☐ Other

Airway Eval.: ☑ No Obvious Abnormality ☐ Significant Obesity (especially neck & facial)

☐ Small Oral Opening ☐ Macroglossia ☐ Other

Planned Sedation/Anesthesia Agent: (Please Circle) Demerol Versed Fentanyl Valium Morphine Other: Propofol

The patient remains an appropriate candidate to undergo the Planned Procedure: ☑ Yes ☐ No

☑ ASA Class I (Normal/Healthy) ☐ Class II (Mild systemic disease) ☐ Class III (Severe systemic disease)

Other:

** Physician discretion to request additional assistance for patients in ASA Class III, IV, and V.

EKG Rhythm: NSR

DATE:	RN SIGNATURE:	Time: 2235	I.V. Fluid Volume: 500 cc	PHYSICIAN SIGNATURE:
6/16/08	[signature]			[signature]

‡ = Modified Ramsey Scale Level of Consciousness Legend:

- 1 = Patient anxious, agitated or restless
- 2 = Patient cooperative, oriented and tranquil
- 3 = Patient responds to command only
- 4 = Patient responds to gentle shaking
- 5 = Patient responds to noxious stimulus
- 6 = Patient has no response to firm nail bed pressure or other noxious stimuli

Sedation start time: 2232

Procedure start time: 2232

Procedure end time: 2235

Reversal agent given:

Medication/dose/route/reason:

Revised: 12/06

SEDATION FLOWSHEET

Patient Label

[redacted] 05/26/08 39

[redacted] [redacted] R (F)

[redacted]

PLIC 0212

XINGTON MI[illegible]CAL CENTER

As soon as the patient receives medications placing him/her in moderate sedation, he/she will be monitored continuously and have documentation every 5 minutes of BP, HR, RR, O_2 Sat & LOC. Post procedure, the patient's physiological status, mental status and pain level are monitored every 15 minutes until discharge criteria are met. (SEE BACK FOR DISCHARGE CRITERIA)

TIME	B/P	HR	RR	O_2 Sat	LOC*	PAIN SCALE	MEDICATION DOSE/ROUTE	NURSING INTERVENTIONS PATIENT RESPONSE
Baseline	125/94	96	18	97%	2			IV insertion: Size [illegible] Site [illegible]
0105	123/84	84	18	95%	2			0105) Pt tolerating procedure well
0110	125/91	102	16	93%	2			
0115	125/84	103	14	95%	2			
0120	125/85	99	12	94%	2			0119) Versed 1mg IVP
0125	125/88	93	14	95%	2			
0125	procedure completed							

Sedation / Anesthesia Plan: ☐ Minimal Sedation ☐ Moderate Sedation Pain control

Only for Moderate Sedation do you need to complete the remainder of the form

Sedation/Anesthesia History: ☒ None ☐ Sleep Apnea ☐ Previous problem sedation/anesthesia _____

☐ Other _____

Airway Eval: ☒ No Obvious Abnormality ☐ Significant Obesity (especially neck & facial)

☐ Small Oral Opening ☐ Macroglossia ☐ Other _____

Planned Sedation/Anesthesia Agent: (Please Circle) Demerol Versed Fentanyl Valium Morphine Other:

The patient remains an appropriate candidate to undergo the Planned Procedure: ☒ Yes ☐ No

☐ ASA Class I (Normal/Healthy) ☒ Class II (Mild systemic disease) ☐ Class III (Severe systemic disease)

Other: _____

** Physician discretion to request additional assistance for patients in ASA Class III, IV, and V.

EKG Rhythm: NSR Time: 0100 I.V. Fluid Volume: [illegible]

DATE:	RN SIGNATURE:	PHYSICIAN SIGNATURE:
6-19-08	[illegible]	[illegible]

* 1 = Modified Ramsey Scale Level of Consciousness Legend:

- 1 = Patient anxious, agitated or restless
- 2 = Patient cooperative, oriented and tranquil
- 3 = Patient responds to command only
- 4 = Patient responds to gentle shaking
- 5 = Patient responds to noxious stimulus
- 6 = Patient has no response to firm nail bed pressure or other noxious stimuli

Sedation start time: 0100
Procedure start time: 0100
Procedure end time: 0125
Reversal agent given: _____
Medication dose/route/reason: _____

Revised: 12/06
[illegible]-550-1

SEDATION FLOWSHEET

[redacted]

PLIC 0213

Lexington Medical Center

1. I hereby consent to and authorize Lexington Medical Center and my physician to perform the following operation or procedure [illegible]

to be performed on (patient name) [illegible], under the direction of Dr.(s) [illegible] and/or other doctor(s) he/she may choose.

2. I know that during the operation or procedure, sometimes an additional or different procedure is needed. I give my permission to the above-named physician and any other physicians and assistants he may choose to perform these procedures if needed.

3. I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the operation or procedure. I give permission to the physician to decide how much and what kind, with the exception of: None. ✓

4. I understand that blood and/or blood products may be needed before, during and/or after the operation or procedure. I understand the risks and the choices available. I (do) (do not) give my permission to the physician to use blood and/or blood products if necessary. I (have) (have not) made prior arrangements for autologous donation, which is the donation and storage of one's own blood for elective medical/surgical procedures.

5. I give the hospital permission to dispose any tissue recovered or amputated parts, if amputation is necessary, during the course of the operation or procedure.

6. I give permission to allow my physician to take pictures of my body parts if needed, during the operation or procedure.

7. My physician or his/her designee has explained to me my diagnosis, the nature of the procedure, the major risks involved, the potential benefits, the probability of success associated with the procedure, the prognosis if the procedure is not done, any alternatives or options, and the potential problems related to recuperation. I understand the explanation provided and no guarantee of results has been given to me. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I voluntarily give my consent to the above operation or procedure.

Witness: [illegible] Signature: [illegible]

Date: [illegible] Time: [illegible] AM PM Relationship to Patient: [illegible]

I have discussed with the patient his/her diagnosis, the nature of the procedure, the major risks, the benefits, the potential complications, the probability of success, the prognosis if the procedure is not carried out, any alternatives, the potential problems related to recuperation, and the possible use of sedation/anesthesia and blood/blood products. I have answered the patient's questions and obtained permission to proceed.

[illegible] Physician Signature

6/18/08 Date

For Surgical, Interventional or Invasive Diagnostic Procedures Use Only

Correct Patient Correct Procedure Correct Site Correct Side Correct Time Correct Position Correct Implants/Devices, as applicable

Date: 6/19/08 Time: [illegible] AM PM

Consent Verification by Surgical/Procedure Team

Physician ✓ Anesthesia [illegible] RN ✓ AT

RN/Lead Tech [illegible]

Perioperative documentation of this process is in the electronic medical record.

Consent to Operation or Procedure

If the patient does not consent to the administration of blood or blood products, notify the physician as soon as possible and have the patient sign the "Refusal of Treatment" form.

7181-445-1
07/07

[redacted] 06/18/08 [illegible]
[illegible], MICHAEL C
[redacted] WELL, THOMAS E, MD
MEDEX [illegible]

LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, South Carolina 29169
803-791-2000

TRANSFER SUMMARY

PATIENT: RUSSELL, MICHAEL C
LOCATION: HNT5P1
ADM #: [redacted]
M.R. #: [redacted]
ADMITTED: 06/19/2008
D: 06/19/2008 1:33 PM
DISCHARGED:
T: 06/19/2008 1:34 PM / cwa
PHYSICIAN: DAVID K LEE, MD
DATE OF BIRTH: [redacted]

DISCHARGE DIAGNOSIS(ES)
1. Left acetabulum fracture.
2. Open left tibia/fibula fracture.

PROCEDURE(S) PERFORMED DURING THIS ADMISSION: Irrigation and debridement and application of a splint with closed reduction of the left tib-fib fracture. This was done on 06/19/2008.

HOSPITAL COURSE: On the day of admission the patient was initially evaluated in the Emergency Department. He was taken emergently to the operating room for an I&D of his left leg. Given his initial pulselessness, arteriogram was ordered and obtained which confirmed complete patency of the lower extremity vessels. Once this was confirmed, the patient was taken to the operating room for an I&D of his left leg. He tolerated the procedure well. Upon further workup and discussion with the family, we had discussed treatment options of his acetabulum fracture. He agreed that treatment via an orthopedic traumatologist would be more appropriate. I contacted Dr. Tucker as well as Dr. Iaquinto at Palmetto Health Richland and they will accept the patient in transfer.

DISPOSITION: The patient is transferred to Palmetto Health Richland in stable condition under the care of Dr. Iaquinto. He will require ambulance transport given the potential instability of his left tib-fib as well as his left acetabulum. If there are any further questions, please do not hesitate to contact me.

TRANSFER DIET: Regular.

ACTIVITY ON DISCHARGE: Continued strict nonweight-bearing on the left lower extremity.

TRANSFER MEDICATIONS

1. Ancef 1 gm IV every 8 hours.
2. Vicodin 1 – 2 tablets p.o. every 4 hours p.r.n. pain.
3. Morphine 2 – 4 mg IV every 4 hours p.r.n. breakthrough pain.

DAVID K LEE, MD

cc:

LEXINGTON MEDICAL CENTER

DEPARTMENT OF PATHOLOGY & LABORATORY MEDICINE
2720 SUNSET BOULEVARD WEST COLUMBIA, SC 29169
(803) 791-2401 www.lexmed.com/laboratories.htm

: RUSSELL,MICHAEL C Room: 595 Physician: Lee, David K., MD Age: 35Y
/ No: [redacted] Loc: HRT5P Sex: M
SN:

Admit Date: 06/19/2008

CBC/DIFFERENTIAL

		NORMALS	UNITS
ATE:	06/18/08		
ME:	2300		
BC	14.7 *	4.0-11.0	K/ul
RC	4.31 *	4.60-6.10	M/ul
HB	13.8	13.5-18.0	gm/dl
HT	39.3 *	41.0-53.0	%
MV	91.2	80.0-98.0	fl
MHC	35.0	32.0-36.0	gm/dL
RW	13.0	11.5-14.5	%
PLT	266	130-400	K/ul
LYMPHOCYTES	18	17-44	%
MONOCYTES	6	0-10	%
GRANULOCYTES	75 *	43-72	%
EOSINOPHILS	1	0-5	%
BASOPHILS	0	0-3	%
AS LYMPHOCYTES	2.70	0.7-5.0	K/ul
AS MONOCYTES	0.90	0.0-1.1	K/ul
GRANULOCYTES	10.90 *	1.7-8.0	K/ul
EOSINOPHILS	0.20	0.0-0.6	K/ul
AS BASOPHILS	0.00	0.0-0.2	K/ul
NUCLEATED RBC	0	0	%
AS NUCLEATED RBC	0.0	0.0	K/uL

CONTINUED

Specimen date/time represents the collect date/time
If the collect date/time is unavailable/ the date/time displayed is the receipts date.

PLIC 0217

::	RUSSELL,MICHAEL C	Room:	595	Physician: Lee, David K., MD	Age: 35Y
ep No:	[redacted]	Loc:	HNT5P		Sex: M
N:					

Admit Date: 06/19/2008

HEMOSTASIS

TE:	06/18/08		
ME:	2300	NORMALS	UNITS
OTHROMBIN TIME	12.1 *	12.3-14.9	sec
R VALUE	0.9		
	INRC		
TT	20.7 *	26.1-34.0	sec
	HEPR		

--FOOTNOTES--
HEPR Therapeutic Range: [55-90] Sec
INRC The INR Value is intended for assessing only those patients stabilized on long term oral anticoagulant therapy. Therapeutic INR range is 2.0-3.0

CONTINUED

Specimen date/time represents the collect date/time.
If the collect date/time is unavailable/ the date/time displayed is the receipte date.

RUSSELL,MICHAEL C Room: 595 Physician: Lee, David K., MD Age: 35Y
p No: [redacted] Loc: HHTSP Sex: M
:
Admit Date: 05/19/2008

CHEMISTRY PROFILES

TE:	06/18/08		
ME:	2300		
		NORMALS	UNITS
UCOSE	113 *	70-100	MG/DL
DIUM	142	135-145	MEQ/L
TASSIUM	4.6	3.5-5.5	MEQ/L
	SLT HEMOLYSIS		
LORIDE	110 *	98-107	MEQ/L
2	17 *	23.0-31.0	MEQ/L
ION GAP	15	7-16	MEQ/L
N	12	5-25	MG/DL
EATININE	0.93	0.65-1.25	MG/DL
	CRE		
LCIUM	8.0 *	8.7-10.2	MG/DL
LIRUBIN (TOTAL)	0.5	0-1.0	MG/DL
LIRUBIN (DIRECT)	0.3	0-0.4	MG/DL
TAL PROTEIN	6.9	6.3-8.2	G/DL
UMIN	3.9	3.5-5.0	G/DL
P	101 *	14-50	U/L
T (SGPT)	63	21-72	U/L
K PHOS	118	50-136	U/L
	195 *	8-78	U/L
R	>60	90-110	mL/min/1.73 sqm
	GFR		

--FOOTNOTES--
E Please note new reference range effective 05/08/08 01200.
C (Multiply result X 1.2 if Afr. Am.)

CONTINUED

Specimen date/time represents the collect date/time
If the collect data/time is unavailable/ the date/time displayed is the receipts date.

Name: RUSSELL,MICHAEL C Room: 595 Physician: Lee, David K., MD Age: 35Y
MR No: [redacted] Loc: HMT5P Sex: M
SS#:

Admit Date: 06/19/2008

DRUGS OF ABUSE

6/18/08				
2300	ALCOHOL	*0.232	[<0.01]	%

CONTINUED

Specimen date/time represents the collect date/time
If the collect date/time is unavailable/ the date/time displayed is the receipt date.