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.

RECORD ON APPEAL - VOLUME V

D. Larry Kristinik
Michael J. Anzelmo
Elizabeth Herlong Brogdon
Kristen E. Horne
Nelson Mullins Riley & Scarborough LLP
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Attorneys for Respondent

RECORD ON APPEAL
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Certificate of Counsel .....

Certificate of Compliance .....

RUSSELL, MICHAEL C | Room: 595 | Loc: HMT5P | Physician: Lee, David K., MD | Age: 35Y | Sex: M

MR#: [redacted]

Admit Date: 06/19/2008

BLOOD BANK TESTS

6/18/08

2000 TYPE SCREEN AND HOLD

ABO/RH(D)	O POSITIVE
ANTIBODY SCREEN	NEGATIVE
NOTE:	TYPE AND SCREEN ONLY

CONTINUED

Specimen date/time represents the collect date/time
If the collect date/time is unavailable/ the date/time displayed is the receipte date.

Erich B. Shaw, MD
John B. Carter, MD
Bill R. McWhorter, MD
Beverly W. Daniel, MD
C. Randy Mallard, MD
K. Karen Xu, MD PhD
William R. Ausenbaug, MD

e:	RUSSELL,MICHAEL C	Room:	595	Physician: Lee, David K., MD	Age: 35Y
ip No:	[redacted]	Loc:	HNT5P		Sex: M
t:				Admit Date: 06/18/2008	

STAT ORDER APPENDIX

COLLECT DATE	TIME	TEST NAME	CREDITED
01/02/08	0910	URINE CHEMICAL EXAM	
	0910	URINE MICROSCOPIC	
06/18/08	2300	CBC HEMOGRAM	
	2300	COMPREHENSIVE METABO	
	2300	DIFFERENTIAL	
	2300	ALCOHOL	
	2300	PROTHROMBIN TIME	
	2300	APTT	
	2300	TYPE SCREEN AND HOLD	

END OF REPORT

Specimen date/time represents the collect date/time
If the collect date/time is unavailable/ the date/time displayed is the receipts date.

PLIC 0222

ROA 1964

LEXINGTON MEDICAL CENTER
2720 Sunset Boulevard
West Columbia, South Carolina 29169
803-791-2000

OPERATIVE NOTE

PATIENT: RUSSELL, MICHAEL C
LOCATION: HNT5P1
ADM. #: [redacted]
M.R. #: [redacted]
ADMITTED: 06/19/2008
D: 06/19/2008 4:43 AM
DISCHARGED:
T: 06/19/2008 7:16 AM / cir
PHYSICIAN: DAVID K LEE, MD
DATE OF BIRTH: [redacted]

DATE OF SURGERY: 06/19/2008

PREOPERATIVE DIAGNOSIS(ES): Open left tibia-fibula fracture.

OSTOPERATIVE DIAGNOSIS(ES): Same.

PROCEDURE(S) PERFORMED: Irrigation and debridement with primary closure of the left leg laceration.

SURGEON: David K. Lee, MD.

[redacted]

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 15 cc.

COMPLICATIONS: None.

DRAINS AND PACKS: None.

DISPOSITION: To the Recovery Room and then transfer to the floor.

TECHNIQUES OF SURGERY: After informed consent was obtained and the correct limb was identified, the patient was taken back to the Operating Room arena. After adequate general anesthesia was induced, the patient was intubated by the anesthesia staff without difficulty. Ancef 1 gm was given intravenously. He was then positioned on the Operating Room table in the supine position. His left leg and lower extremity were

PLIC 0223

prepped and draped in the usual sterile fashion using Betadine scrub and paint. The laceration was inspected. It was an 8-cm oblique laceration over the anterolateral aspect of the lower leg. He did have some abrasions adjacent to the laceration. The laceration itself was cleaned. There was no significant debris. The superficial peroneal nerve was sitting within the wound and was contused but was intact. Next, using pulsatile lavage, 9 L of normal saline was then used to copiously irrigate the fracture site. The laceration was then reapproximated using 3-0 nylon in the vertical mattress fashion. A sterile Xeroform 4 x 4 dressing was applied. The extremity

was placed in a well-padded fiberglass trilaminar splint. Post-reduction films were confirmed to provide anatomic reduction of the fracture. The patient was awakened and extubated in the Operating Room and taken to the Recovery Room in stable condition without apparent complication.

DAVID K LEE, MD

cc:

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: RUSSELL,MICHAEL C

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079876
REPORT NO: 0619-0467

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: DAVID K LEE MD

ROOM: 595-1
PT LOCATION: HNT5P1
LEEDAV ORT

REPORT STATUS: Signed

ORDERED BY: DAVID K LEE MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0619-0001 OR/FLUORO 1 HR LEFT

DATE OF EXAM: 06/19/08

CLINICAL DATA: 35M, LEG INJURY, PROCEDURE DONE IN OR

FLUOROSCOPY:

Fluoroscopy was provided by means of a portable image intensifier. No films were taken.

CDG

RADIOLOGY DEPARTMENT

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0619-0001 OR/FL1 (76000)
EXAM TECH: LKMOO
HNT5P1/595
REP RELEASED BY: RADDEP REF 06/19/08 1355
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

PLIC 0225

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079846
REPORT NO: 0619-0097

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0619-0033 RAD/LUMBAR SPINE - 2 or 3 VIEWS

DATE OF EXAM: **06/19/08**

CLINICAL DATA: 35M, INJURED LUMBAR SPINE

LUMBAR SPINE (3 VIEWS):

Three views of the lumbar spine, including a spot lateral of the lumbosacral region, show the bony structures to be intact. Disc spaces are well maintained. The facets are within normal limits. There is a normal lumbar curve.

IMPRESSION: Negative lumbar spine.

NOTE: Urographic contrast is present within the renal collecting system and within the urinary bladder apparently from recent CT study. Left acetabular fracture is reidentified.

MAS

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: **0619-0033 RAD/LUM (72100)**
EXAM TECH: **TNBUR**
HNT5P1/595
REP RELEASED BY: **HAYJOH RAD 06/20/08 0910**
ADD RELEASED BY:
DISC DATE:

PT LOC/ROOM:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: RUSSELL,MICHAEL C

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079846
REPORT NO: 0619-0095

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0619-0032 RAD/CERV SP 2 OR 3 VIEWS OR TRAUMA

DATE OF EXAM: **08/19/08**

CLINICAL DATA: 35M, INJURED CERVICAL SPINE

CERVICAL SPINE:

COMPARISON: None.

Radiographic examination of the cervical spine consists of AP, lateral, swimmer's lateral, and odontoid views. Alignment of all seven cervical vertebrae is normal. Osseous structures, including the odontoid, appear intact without signs of an acute fracture. Soft tissues are nonspecific.

IMPRESSION: Unremarkable cervical spine.

MAS

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0619-0032 RAD/CERVTRA (72040)
EXAM TECH: TNBUR
HNT5P1/595
PT LOC/ROOM:
REP RELEASED BY: HAYJOH RAD 06/20/08 0910
ADD RELEASED BY:

PLIC 0227

DISC DATE:
ED DISC DIAG:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079828
REPORT NO: 0619-0077

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0279 RAD/TIBIA&FIBULA/LOWER LEG LEFT

DATE OF EXAM: **06/18/08**

CLINICAL DATA: 35M, INJURED LEFT LEG

LEFT TIBIA-FIBULA:

FINDINGS: AP and lateral views of the left tibia and fibula are made through a lower leg splint. Artifacts compromise evaluation of the proximal tibia and fibula which appear grossly normal. There are acute transverse fractures through the distal shafts of both tibia and fibula, again partially obscured by the overlying metallic splint.

MAS

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0618-0279 RAD/TIB/FIB (73590)
EXAM TECH: TNBUR
HNT5P1/595
REP RELEASED BY: HAYJOH RAD 06/20/08 0910
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079823
REPORT NO: 0619-0071

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0274 RAD/FEMUR LEFT

DATE OF EXAM: **06/18/08**

CLINICAL DATA: 35M, LEFT FEMUR PAIN

LEFT FEMUR (2 VIEWS):

Two views of the left femur show no traumatic or pathologic changes.

NOTE: Note comments on femur position on the pelvic radiograph report.

MAS

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0618-0274 RAD/FEM (73550)
EXAM TECH: TNBUR
HNT5P1/595
REP RELEASED BY: HAYJOH RAD 06/20/08 0910
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: RUSSELL,MICHAEL C

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079823
REPORT NO: 0619-0070

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: RICK HALL MD

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0273 RAD/PELVIS

DATE OF EXAM: 06/18/08

CLINICAL DATA: 35M, PELVIC PAIN

PELVIS:

Single view was obtained. Backboard artifacts obscure anatomy of the left hemipelvis but there appears to be an acute fracture of the left acetabulum with superior subluxation of the femoral head which has impacted the acetabular roof. No other obvious fractures are visible. There is evidence of previous right inguinal hernia repair.

AKH

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0618-0273 RAD/PEL (72170)
EXAM TECH: TNBUR
HNT5P1/595
REP RELEASED BY: HAYJOH RAD 06/20/08 0910
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079823
REPORT NO: 0619-0069

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0272 RAD/CHEST 1 VIEW

DATE OF EXAM: **06/18/08**

CLINICAL DATA: 35M, CHEST PAIN

AP SUPINE CHEST:

FINDINGS: Backboard artifacts are present. Heart, lungs, mediastinum and visualized osseous structures are within the limits of normal for this technique.

MAS

JOHN W HAYNES MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: **0618-0272 RAD/CX1 (71010)**
EXAM TECH: **TNBUR**
HNT5P1/595
REP RELEASED BY: **HAYJOH RAD 06/20/08 0910**
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079815
REPORT NO: 0619-0062

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0264 RAD/TIBIA&FIBULA/LOWER LEG LEFT

DATE OF EXAM: **06/18/08**

CL NICAL DATA: 35M, MOTORCYCLE ACCIDENT, LEFT LOWER EXTREMITY PAIN

LEFT LOWER EXTREMITY - TWO VIEWS:

COMPARISON: None.

FINDINGS: Acute transverse fractures that are overlapping involving the distal left tibial and fibular metadiaphysis is noted. The fibular fracture appears comminuted. Visualized left ankle mortise appears intact.

AKH

KEITH A MCGUIRE MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0618-0264 RAD/TIB/FIB (73590)
EXAM TECH: TNBUR
HNT5P1/595
REP RELEASED BY: MCGKEI RAD 06/19/08 1001
ADD RELEASED BY:
DISC DATE:
ED DISC DIAG:

PT LOC/ROOM:

RUSSELL,MICHAEL C

PLIC 0233

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: **RUSSELL,MICHAEL C**

AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0079836
REPORT NO: 0619-0254

ADMITTING DR: LEE, DAVID K MD
ORDERING DR: **RICK HALL MD**

ROOM: 595-1
PT LOCATION: HNT5P1
HALRIC EM

REPORT STATUS: Signed

ORDERED BY: RICK HALL MD
LOCATION: ADM IN HNT5P1 595
STUDY TYPE: 0618-0056 SPP/ARTERIOGRAM EXTREMITY UNI;
0618-0057 SPP/CATH SEL ABDOMEN PELVIS 1ST;
0618-0058 SPP/MOD CS >5 YR FIRST 30 MINUTES

DATE OF EXAM: **06/18/08**

CL NICAL DATA: 35M INVOLVED IN MOTOR VEHICLE ACCIDENT WITH LEFT LEG FRACTURES

PELVIC AND LEFT LEG ARTERIOGRAM:

PROCEDURE: Informed consent was obtained from the patient's wife by staff. The right groin was prepped and draped. 1% Lidocaine was used as local anesthesia. The right common femoral artery was accessed using a Microaccess system and a 4Fr vascular sheath placed. Over a 0.035 guidewire a universal flush catheter was positioned at the level of the distal abdominal aorta and an oblique view of the pelvis performed. The catheter was then manipulated across the aortic bifurcation past the level of the left common femoral artery. Digital imaging was performed from the level of the left hip to the level of the distal left foot. Following review of the films the catheter and sheath were removec and hemostasis achieved with manual pressure. No acute complications were encountered.

FINDINGS: The pelvic arteriogram shows no atherosclerotic disease or flow-limiting stenosis. Imaging down the left leg shows no spasm or injury to the left common femoral artery. The superficial femoral artery s widely patent with no significant atherosclerotic disease or vasospasm.

Popliteal artery remains well defined with no injury. Three vessel run-off is documented proximally. Vasospasm is noted within the anterior and posterior tibial arteries but pseudoaneurysm or definite intimal injury is not identified. Both the anterior and posterior tibial arteries are seen across the level of the ankle. Peroneal artery can be seen to the level of the ankle.

IMPRESSION: Vasospasm of the anterior and posterior tibial arteries at and just above the level of the patient's tib/fib fracture. Both vessels are well defined across the ankle.

AKH

EDWIN R HUDSON MD

REPORT STATUS: Signed

ORDER#/PROCEDURE: 0618-0056 SPP/ARTEXTU (75710); 0618-0057 SPP/SCAP1 (36245); 0618-0058 SPP/MODCS>5 (99144)
EXAM TECH:

PT LOC/ROOM:

HNT5P1/595
REP RELEASED BY: HUDEDW RAD 06/20/08 1544
ADD RELEASED BY:
DISC DATE: 06/20/08
ED DISC DIAG:

RUSSELL,MICHAEL C

PLIC 0235

PENNSYLVANIA LIFE INSURANCE CO.

May 15, 2009

Palmetto Health Richland
5 Richland Medical Park Dr.
Columbia, SC 29203
ATTENTION: Medical Records

RE: Patient: Mike Russell
Date of Birth:
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

PENNSYLVANIA LIFE INSURANCE CO.

May 15, 2009

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

PLIC 0237

July 16, 2009

Review of the medical record of: Mike Russell Date of Birth: [redacted]

Mr. Russell is a 35-year-old owner of a construction company, who was involved in a motor cycle accident on 06/18/2008. Reportedly, the car in front of him had stopped, and Mr. Russell ran into the back of the car with his motorcycle. He was originally seen at Lexington Medical Center, was treated there for several days and was transferred to Richland on 06/24/2008. While at Lexington Medical Center, after work up in the emergency room, Mr. Russell was admitted and had a tibial pin placed for traction until transfer could be arranged. After transfer, to Lexington Medical Center, Mr. Russell underwent in intramedullary nailing of the left tibia fracture and open reduction internal fixation of the left acetabular fracture, both of which was performed on 06/24/2008. At seven weeks after surgery, the x-rays demonstrated satisfactory reduction and position of both the acetabular fracture and the tibia fracture. By 10/07/2008, it was evidence that there was slow healing or non-healing of the tibia fibula fracture and the patient requested a second orthopedic opinion. On 11/03/2008, in a follow-up visit with his orthopedic surgeon, Dr. John laquinto it was noted that there was minimal healing of the tibia/ fibula fracture. Apparently on 3/17/09 the patient went to a different orthopedic surgeon for a second opinion. We do not have these records.

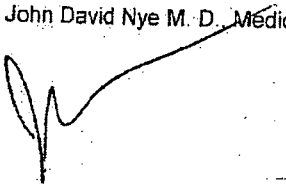
With respect to the non-healing tibial/fibular fracture, this is not really uncommon, and eventually the orthopedic surgeons should be able to get this to heal, even if it takes a second operation. Fortunately, this is not in a joint, therefore, this type of injury typically not a long-term disability associated is associated frequently.

With respect to the acetabular fracture, these vary on postoperative repairative time, and postoperative degenerative/arthritic changes and symptomatology. It is not unusual to take six months to a year to heal from this type of fracture and repair. We are now more than one year from this injury and repair, and Mr. Russell should have obviously reached maximum medical improvement with respect to the acetabular fracture.

It would be valuable to obtain the initial emergency room records and laboratory studies, from Lexington medical center.

It would be valuable to obtain the second opinion report any new x-rays of these areas for medical review, as well as office notes to help us determine how his medical condition is improving

John David Nye M. D. Medical Direct



Referral to Medical Director

Date: June 30, 2009

Insured: Mike Russell Policy No.: [redacted]9360 | 0809-00062

Issues & Questions:

In your medical opinion and in retrospect of the medical information, please give me a timeline on the insured healing process.

Can an accident of this nature cause (71593) osteoarthrosis and sacrolitis?

In your medical opinion what is the approximate timeline for recovery for an injury of this nature? (In lieu of the complication insured is having)

Referred By: Ella Lee Ext.: 2492

Medical Response:

Medical Consultant: _____ Date: _____

PLIC 0239

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 0240

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 6/30/09

Rus

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

CLAIM NUMBER: 0809-00062

TAXPAYER I.D. NUMBER | L | REVIEW DATE | PAY TYPE

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED 06/18/09
CHANGE TO:

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted] 93e0		8040			✓							D

REF	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12	TD	04250A	05250A			
4	12	TD	04250A	05250A			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0241

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

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			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. Juarez + Dr. Dedmond - Lexington Ortho pedics 146 N. 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 26

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 0242

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

3a Next Appointment Date:
   7-8-09

Dates of treatment since last report:

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?
   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: [signature]

ADDRESS: 146 North Hospital Dr W. Col A S.C. 29169 TELEPHONE 803-936-7230

PLIC 0243

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	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
609	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

INSURANCE INQUIRIES / PAYMENTS TO:
LEXINGTON ORTHOPAEDICS
146 N HOSPITAL DR STE 140
WEST COLUMBIA, SC 29169
803-936-8882

0561 726249 000562 000562 0000 708001 920965902

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

920965S1

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 1987

PLIC 0245

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 05-20-09
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 0246

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: 5/20/09

RVS

CLAIM NUMBER: 0809-00062

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] 9360	0120	8040			✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OP
2	12		03/25/09	04/25/09			
4	12		03/25/09	04/25/09			

MANUAL DRAFT NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0247

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	803-955-0339	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. Bedmond - 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 01
Dr. Bedmond - April 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 exercises, reading, etc.

DATE: 4-29-09 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0248

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. # [redacted]

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 0249

ROA 1992

PLIC 0250

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

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 0251

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Russell

DATE: 04/10/09

Rus

CLAIM NUMBER: 080900062

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]9360	0120	8090			✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
0	12		022504	032509			
4	12		X	V			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0252

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 ~~Work~~	803-513-0575		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 897 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 0253

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

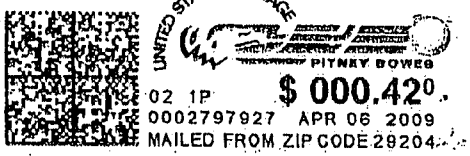
DATE: 4/1/09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-749-8585

PLIC 0254

ROA 1997

Russell



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

32591+2355

PLIC 0255

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 0256

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 03/16/09

RWB

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]9360	0120	8090			✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12	TD	01/25/09	02/25/09			
4	12	TD	01/25/09	02/25/09			

MANUAL DRAFT NUMBER BD

DRAFT DATE

DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0257

PENNSYLVANIA LIFE INSURANCE COMPANY

P.O. Box 12355, Pensacola, FL 32591-2355

8050

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	803-955-0329	Age: 36	Claim No: 02-001-001-080900062
	~~Work~~ Cell	803-513-0525		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 Ste 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]18

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 0258

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 presat
6. When did or will your patient be able to resume full work?	Unknown at presat
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]

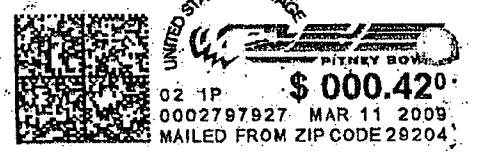
Must be furnished under authority of the law

DATE: 3/2/09 SIGNED: [signature]

ADDRESS: PO Box 1997 Irmo, SC 29063 TELEPHONE 803-741-8585

PLIC 0259

Russell



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

32591#2355

ROA 2002

PLIC 0260

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	**DATE AND TIME: March 12, 2009**	
Policy Number and Policy Form: [redacted]9360		
Claimant Name: Mike Russell		
Caller Name: Insured		
Telephone Number:	**Incoming? x**	**Outgoing?**
Alternate Telephone Number:	**Claim Number: 0809-00062**	

NATURE OF CALL

Received call from insured. Claim has not been paid since the end of january. He said he had to wait 20 days for the doctor to fill out the scf form. He refused to fill out any forms for anyone until the manager stepped in. He is going for a 2nd opinion on 03/17/09 to see another ortho doctor. He said he wife mailed the form off yesterday and we should be receiving it. I will check again on Monday, March 16, 2009.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

Signature: Ella Lee	Date: 03/12/09

01-28-09;03:48PM;

Cathy Hales

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: 02-001-001-0B0900062
	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 Ortho, 3 Richland 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

RECEIVED
JAN 28 2009
PENSACOLA 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. 4-87

PLIC 0262

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	Diagnosis: 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
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. 3-96

PLIC 0263

ATTENDING PHYSICIANS STATEMENTS

408 MacDade Blvd
Collingdale, PA 19023
Telephone (610) 534-5424
Fax (888) 550-5424

" Automation In Electronic Medical Data Retrieval "

Order #: 660873

Insurance Company: Pennsylvania Life Insurance

Medical Records received on: 12/5/2008

Policy Number: [redacted]9360

Patient's Information

MICHAEL RUSSELL

DOB: [redacted]
SSN:

Provider's Information

DR. JOHN LAQUINTO
3 MEDICAL PARK DRIVE, SUITE 330
COLUMBIA, SC 29203
Phone: 803-434-6958
Fax: 803-434-8537

Facility:

Dates of service requested: Last Five (5) Years.

Thank you, and we sincerely appreciate your business!
Attending Physicians Statements

The following records are pages submitted to our office by the above referenced provider.

******* INSTANT BILL *******
PREMIER ORTHOPEDIC SPECIALISTS
PO BOX 402145
ATLANTA, GA 30384-2145

Office PH: (803) 434-8354 Home Ph: (803) 955-0329 Work Ph: (803) 513-0575

MICHAEL C RUSSELL

ACCT: [redacted] Date: 12/05/08

Last Pmt
11/12/08 $20

PAT NAME
0 MICHAEL [redacted]

DIAGNOSIS CODES
1 - 823.92
2 - 808.0
3 - 835.01
4 - 823.01
5 - MR

DOCTORS
1 - John Iaquinto

STATE ID EMPL ID
[redacted]

SERVICE DATE	DATE POSTED	PAT NUM	D R	D G	PROC	MOD	DESCRIPTION	CHG/PMT
06/24/08	07/15/08	0	1	1	27759		OPEN TX TIB FX BY IMPL W/	3390.00
06/24/08	07/15/08	0	1	2	27226	22	OPEN TX POST/ANT ACETAB F	2997.00
06/24/08	07/15/08	0	1	3	20650		INSRT WIRE/PIN W/TRAC-SEP	361.00
07/14/08	07/17/08	0	1	4	99024		POSTOP F/U VISIT INCL GLO	.00
08/11/08	08/12/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
08/29/08	08/29/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	15.00
08/29/08	08/29/08				PMT		Check from Other-atty	-15.00
06/24/08	09/09/08				PMT		Other from Patie-cc sg	-20.00
09/22/08	09/25/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-361.00
11/03/08	11/04/08	0	1	2	99212		OFC/OUTPT E&M ESTAB MINOR	67.00
11/10/08	11/12/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	20.00
06/24/08	11/12/08				ADJ		Companion Adj	3370.00
06/24/08	11/12/08				ADJ		Companion Adj	2997.00
06/24/08	11/12/08				ADJ		Companion Adj	361.00
11/10/08	11/12/08				PMT		Other from Patie-	-20.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-361.00
							Total	$67.00

REF PHYS :

TAX ID:

PLIC 0265

******* INSTANT BILL *******
PREMIER ORTHOPEDIC SPECIALISTS
PO BOX 402145
ATLANTA, GA 30384-2145

ACCT: [redacted] Date: 12/05/08

Last Pmt
11/12/08 $20

Office PH:(803) 434-8354 Home Ph:(803) 955-0329 Work Ph:(803) 513-0575

MICHAEL C RUSSELL

PAT NAME
0 MICHAEL [redacted]

DIAGNOSIS CODES

1 - 823.92
2 - 808.0
3 - 835.01
4 - 823.01
5 - MR

DOCTORS

1 - John Iaquinto

STATE ID

EMPL ID [redacted]

SERVICE DATE	DATE POSTED	PAT NUM	D R	D G	PROC	MOD	DESCRIPTION	CHG/PMT
06/24/08	07/15/08	0	1	1	27759		OPEN TX TIB FX BY IMPL W/	3390.00
06/24/08	07/15/08	0	1	2	27226	22	OPEN TX POST/ANT ACETAB F	2997.00
06/24/08	07/15/08	0	1	3	20650		INSRT WIRE/PIN W/TRAC-SEP	361.00
07/14/08	07/17/08	0	1	4	99024		POSTOP F/U VISIT INCL GLO	.00
08/11/08	08/12/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
08/29/08	08/29/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	15.00
08/29/08	08/29/08				PMT		Check from Other-atty	-15.00
06/24/08	09/09/08				PMT		Other from Patie-cc sg	-20.00
09/22/08	09/25/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-361.00
11/03/08	11/04/08	0	1	2	99212		OFC/OUTPT E&M ESTAB MINOR	67.00
11/10/08	11/12/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	20.00
06/24/08	11/12/08				ADJ		Companion Adj	3370.00
06/24/08	11/12/08				ADJ		Companion Adj	2997.00
06/24/08	11/12/08				ADJ		Companion Adj	361.00
11/10/08	11/12/08				PMT		Other from Patie-	-20.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-361.00
							Total	$67.00

REF PHYS :

TAX ID:

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 11/03/2008 DOB:

11/03/2008

ATTENDING PHYSICIAN: John M. Iaquinto, MD

HISTORY OF PRESENT ILLNESS: Patient's date of injury was 06/18/2008. He is status post ORIF of his left acetabulum, IM rod of his left open tibia. He comes in today on 11/03/2008. He states he is having pains in his hip, knee, and ankle. He is ambulating with his left lower extremity approximately 3 to 4 hours a day. Today with the cold and rainy-type day, he states he is having a lot of pain in his hip.

PHYSICAL EXAM: We can internally and externally rotate at the hip, flex, and extend although this does cause him some discomfort. He can flex his knee past 90, do a straight-leg lift, and dorsiflex and plantar flex his toes. All the surgical wounds have healed. He is neurovascularly intact. Skin is warm, dry, and intact. No sign of infections. No drainage from any of his wounds.

LABORATORY DATA/IMAGING: X-rays reviewed with Dr. Iaquinto show some traumatic arthritis at the left hip and minimal healing, but well aligned left tibia.

ASSESSMENT: The patient is status post open reduction, internal fixation of left acetabulum and intramuscular rodding of his left open tibia fracture.

PLAN: Patient given Celebrex 200 mg 1 p.o. b.i.d. for his arthritic pain. He is given a referral for Pain Clinic for some chronic pain of his hip. He will follow up in 16 weeks. We will get AP and lateral of his left tibia. We had a discussion with the patient and his wife that if the tibia still continues not to heal, when he returns in 4 weeks we may need to talk about further surgery to his tibia. Again, we reiterated that the patient needs to stop smoking. All other questions were answered. He does not need to wear his Cam Boot walker anymore. He may walk on the leg as pain allows; crutches or cane at his discretion. We will see the patient back in 16 weeks.

John M Iaquinto, MD

Dictated by: Michael D. Richards, PA-C

MR:th
D: 11/03/2008 1:56 P T: 11/03/2008 4:31 P
Job #: 000231222 T Job #: 40223777 Doc #: 12802293
cc:

Original

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537
OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 09/22/2008 DOB:

09/22/2008

ATTENDING PHYSICIAN: John M. Iaquinto, MD

OFFICE NOTE

HISTORY: Mr. Russell is status post a left acetabulum and IM rodding of his grade IIIA open left tibia. The patient comes in today. He is 3 months out from his surgery. He has complaints of when he is standing up straight he gets pain in the muscles going from his buttocks down to the lateral side of his knee. As long as he is not standing up straight, he does not have any pain in his leg in this area. Denies numbness or tingling. He has no pain with range of motion of the left hip or in the seated position.

PHYSICAL EXAMINATION: On exam, I can internally-externally rotate at the hip without causing any pain. He can flex and extend without any pain. When we had him stand up, he could reproduce the pain that he gets running down the lateral side of his leg. He is able to dorsiflex and plantarflex his foot. He is neurovascularly intact. His surgical wounds have healed. His open wound on his left tibia has healed. X-rays reviewed with Dr. Iaquinto.

ASSESSMENT: The patient is status post intramedullary rod of his left open tibia, open reduction and internal fixation of his left acetabulum.

PLAN: Again, reiterated that the patient needs to stop smoking. He still smokes over a pack per day. He wants his open tibia fracture to heal. Hopefully, he can stop smoking. We will allow him to increase his weightbearing to weightbearing as tolerated as long as he keeps the Cam boot walker on. He states that he has done well ambulating with the Cam boot on.

Original

PALMETTO HEALTH ORTHOPEDICS
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-6958

Does not have any pain in his tibia. When he returns in 6 weeks, we will get an AP/lateral of his left tibia, AP pelvis, and he was given Tylenol, No. 3 one to 2 q.8 hours, #60. Discussed with patient this will be his last refill. We will not call any more pain medications in at this time.

John Iqauinto, MD

Dictated by: Michael D. Richards, PA-C

MR:ln
D: 09/22/2008 1:37 P T: 09/23/2008 12:00 P
Job #: 000284190 T Job #: 40138412 Doc #: 1260235
cc:

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 08/11/2008 DOB:

08/11/2008

ATTENDING PHYSICIAN: John M. Iaquinto, MD

SUBJECTIVE: Returns for scheduled follow up now about seven weeks status post ORIF left acetabulum and IM nail left tibia. Pain control is improving steadily. He still has pills left from the most recent prescription.

OBJECTIVE: X-ray left acetabulum shows unchanged satisfactory fracture reduction and implant position. X-ray left tibial similarly shows unchanged satisfactory fracture reduction and implant position.

EXAM: Left lower extremity good sitting posture. Flexion symmetrical to the normal right side. Extension within about 20 degrees of full extension. Noticeable quadriceps atrophy. All wounds and incisions well healed and benign. Moderate foot swelling.

ASSESSMENT: Healing left acetabulum and tibia shaft fracture.

PLAN: Initiate partial weight bearing about 25%-30% body weight on the left and initiate home quadriceps exercise program and hip abductor strengthening program.

ROV: Six weeks for exam, x-ray left tibia.

Original

PALMETTO HEALTH ORTHOPEDICS
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-6958

John Iaquinto, MD

JM:tn
D: 08/11/2008 1:40 P T: 08/12/2008 2:36 P
Job #: 000209485 T Job #: 4D101145 Doc #: 1240383
cc:

PATIENT: Russell, Michael

OUTPATIENT CONSULTATION REPORT

Original

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-0537

OUTPATIENT VISIT

PATIENT: Russel, Michael MR#:
VISIT DATE: 07/14/2008 DOB:

ATTENDING: John M. Iaquinto, MD.

SUBJECTIVE: Three weeks status post ORIF of left acetabulum posterior wall fracture/dislocation and IM nail and debridement of the open left tibial fracture. Reports pain is tolerable.

OBJECTIVE: X-ray of left acetabulum and pelvis shows satisfactory fracture reduction with satisfactory implant position, maintained with a congruent hip joint. X-ray of left tibia shows satisfactory fracture reduction with satisfactory implant position.

Left lower extremity flexion to 90, extension to about 45, all atraumatic wounds, and the incision is benign and well healed with mild scabbing.

ASSESSMENT: Left acetabulum fracture and left open tibia fracture.

PLAN: Focus on re-extension. I discussed physical therapy, but he feels he will be able to do this on his own. ROV 4 weeks for exam; x-ray left tibia. Continue toe-touch weightbearing.

John Iaquinto, MD

JMI:hs
D: 07/14/2008 2:06 P T: 07/15/2008 10:44 A
Job #: 000161479 T Job #: 742588 Doc #: 1227377
cc: John M. Iaquinto, MD

Original

Operative Report

RUSSELL, MICHAEL C - [redacted]

Result type: Operative Report
Result date: 24 June 2008 14:03
Result status: Transcribed
Result title: Operative Report
Performed by: Iaquinto MD, John M on 24 June 2008 14:03
Encounter info: [redacted] Richland, IPR-Inpatient, 06/20/08 - 07/01/08

Operative Report
DATE OF OPERATION: 06/24/2008

DATE OF SURGERY: June 24, 2008

PREOPERATIVE DIAGNOSES:
1. Fracture dislocation left acetabulum posterior wall.
2. Grade 3a open tibia fracture, left.

POSTOPERATIVE DIAGNOSES:
1. Fracture dislocation left acetabulum posterior wall.
2. Grade 3a open tibia fracture, left.

OPERATIVE PROCEDURE:
1. Removal of traction pin from left tibia following previous insertion of tibial traction pin left tibia and intramedullary nail left tibia fracture - CPT code 27759.
2. Open reduction, internal fixation left acetabulum fracture - CPT code 27226.

SURGEON: John M. Iaquinto, MD

ATTENDING: John M. Iaquinto, MD

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 300 mL.

SPECIMEN: Multiple osteochondral fragments from left acetabulum.

COMPLICATIONS: None.

INDICATIONS: Unstable long bone fractures, open, and fracture dislocations of weightbearing joints requiring open anatomic reduction and stable internal fixation for optimal patient outcome.

DESCRIPTION OF OPERATION: Following the achievement of adequate general anesthesia, the patient was removed from traction and the small wire tibial traction pin was cut and removed without difficulty under sterile conditions. The patient was transferred to a radiolucent OSI table in

Operative Report RUSSELL, MICHAEL C [redacted]

supine position and tourniquet applied to the left thigh and then splint removed from the left leg. The traumatic wound was noted to be benign and the fracture was noted to be grossly unstable. A tourniquet was applied to the left thigh and the left lower extremity prepped and draped in normal sterile orthopedic manner, exsanguinated by elevation and tourniquet inflated to 300 mmHg. The knee was placed over a triangle and a medial parapatellar incision made and carried down through the subcutaneous tissue. Entry portal site identified and an entry portal made and guidepin inserted and then an entry portal made with a rigid reamer. Guidepin passed anterograde down the proximal fragment across the fracture site and into a satisfactory position in the distal tibia. The tibial canal was then reamed in 0.5 mm increments from 9 to 11 mm and then a 10 mm x 30 mm Synthes tibia nail was inserted to an appropriate depth without difficulty. Cross-locking with 1 screw was accomplished utilizing freehand technique. The fracture site was impacted with backslaps on the driver and then proximal cross-locking with 1 screw was accomplished utilizing the proximal cross-locking guide. The operative incision was then closed in layers with staples on the skin. A sterile dressing was applied.

The patient was then transferred to the right lateral decubitus position on the beanbag and a new prep and drape of the left hip area was carried out. A longitudinal lateral incision made and carried down through the subcutaneous tissue. Fascia lata identified and divided in line with the incision. The gluteus maximum fibers were bluntly divided in line with the incision. Piriformis tendon identified, transected at its insertion and retracted. Sciatica identified, preserved and protected throughout the procedure. There was extensive soft tissue damage in the superior-posterior aspect in the area of the posterior wall fragment. The posterior wall was noted to be more extensively damaged than a typical posterior wall and was noted to be segmentally fractured into 3 pieces with multiple loose osteochondral fragments and multiple 1 cm diameter marginal impaction fragments which were elevated, but unable to be stabilized adequately and were removed for specimen. The femoral head also was noted to have a large sheared cartilage fragment. The wound was then copiously irrigated with normal sterile saline and then the head was reduced and then the segments of the posterior wall in succession were reduced and stabilized with smooth pins. These were then fixed with interfragmentary screws and then intraoperative image demonstrated satisfactory fracture reduction, satisfactory screw placement and then a 8-hole 3.5 mm pelvic reconstruction plate was then bent appropriately and screws were drilled, measured and inserted in succession. Following this, intraoperative biplane imaging demonstrated satisfactory fracture reduction and satisfactory implant position with the congruent hip joint. The wound was copiously irrigated. Piriform tendon repaired to its insertion and hip joint capsule repaired and then fascia lata repaired with interrupted #1 Vicryl sutures. A sterile dressing was applied. Sponge, instrument and needle counts were taken and found to be correct. The patient tolerated the procedure well and arrived to the recovery room in satisfactory condition.

Operative Report

RUSSELL, MICHAEL C - [redacted]

JMI:hs
D: 06/24/2008 1:19 P T: 06/24/2008 2:03 P
Job #: 000138205 T Job #: 432112 Doc #: 1217751
cc: John M. Iaquinto, MD

Completed Action List:
* Perform by Iaquinto MD, John M on 24 June 2008 14:03

ATTENDING PHYSICIANS STATEMENTS

408 MacDade Blvd
Collingdale, PA 19023
Telephone (610) 534-5424
Fax (888) 550-5424

" Automation in Electronic Medical Data Retrieval "

Order #: 660874

Insurance Company: Pennsylvania Life Insurance

Medical Records received on: 12/12/2008

Policy Number: [redacted]9360

Patient's Information

MICHAEL RUSSELL

72

DOB:
SSN: [redacted]

Provider's Information

DR. TERRY NAGEL
5535 PLATT SPRINGS ROAD,
LEXINGTON, SC 29073
Phone: 803-951-1880
Fax: 803-951-0384

Facility: LEXINGTON FAMILY PRACTICE

Dates of service requested: Last Five (5) Years.

Thank you, and we sincerely appreciate your business!
Attending Physicians Statements

The following records are pages submitted to our office by the above referenced provider.

Lexington Family Practice White Knoll

Name: Mike Russell DOB: [redacted]

Chart #: [redacted]

Vital Sign / Flow Sheet

Date	Temp	PR/RR	BP	Ht/Wt	Chief Complaint	Pain	Initials
N 10-7-08	98.8	94. 20	132/74	180	34 Needs referral - Ortho for knee pain	Yes	ZB
			6/18			Yes	
					Rx for	Yes	
					Compound for	Yes	
					(L) hand for	Yes	
					Acetabular fx	Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	

8360-011-1 (05/06)

PLIC 0277

Lexington Family Practice White Knoll

Name: Mike C. Russell DOB: [redacted]

Chart #: [redacted]

Vital Sign / Flow Sheet

Date	Temp	PR/RR	BP	Ht/Wt	Chief Complaint	Pain	Initials
N 10/11/07	97.0	92/20	146/92	172#	(M) 55 C/O TL MONTAL OF (M) FOOT [illegible]	Yes	[illegible]
					↑ C ATTEMPTING TO LIFT VS FLEXION	Yes	✓
(H) 01/04/08	97.5	88/16	128/86	165#	(M) 55 PT FELL & HIT [illegible] MID (C) SPINE ON CORNER OF TABLE. SEEN @ OLOGIC CLINIC TO DOES	Yes	
					STILL HAVE PAIN @ OFFICE VS MORE DIFFICULTY SLEEPING & ADL	Yes	✓
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	

8360-011-1 (05/06)

PLIC 0278

Lexington Family Practice White Knoll

5535 Platt Springs Road
Lexington, South Carolina 29073

PATIENT: RUSSELL, MIKE C		VISIT DATE: 10/07/2008	
PATIENT #: [redacted]	XXX-X1-7773	D: 10/07/2008 4:0 PM	
PHYSICIAN: TERRY L NAGEL, DO		T: 10/08/2008 5:19 PM / bjl	
		DATE OF BIRTH: [redacted]	

S: Patient is a 36-year-old white male who presents requesting referral to orthopedics to have a second opinion. He was involved in a motor vehicle accident involving his motorcycle on 06/18/2008, where the car in front of him stopped, and he rear-ended the back of the car. This happened at I26 near exit 115. He was originally seen at Lexington Medical Center, was there for several days, and the orthopedic guys there transferred him over to Richland, where he subsequently had repair of what sounds to be a TIB/FIB fracture, left lower leg, and also had an acetabular fracture. This was repaired by Dr. Iaquinto. Patient just saw him on 10/06/2008. It was actually one of his assistants who recommended that he start bearing weight, but that the TIB/FIB fracture is not healing as it should. Patient is confused and questions if he should put full weight on this leg, given that it is not healing. Because of this he is requesting second opinion from another orthopedic doctor. He does wear a cam walker and has crutches now. CURRENT MEDICATIONS: Tylox. ALLERGIES: None known. ROS: As above; otherwise negative.

O: VITAL SIGNS: Stable; afebrile. Please see enclosed in chart. GENERAL: Alert x3, in no acute distress, nontoxic-appearing. LEFT LOWER EXTREMITY: Post-op surgical changes, some slight swelling in lateral aspect of lower leg.

A: Nonhealing TIB/FIB fracture.

P: Referral to orthopedics for second opinion, per patient's request. His main concern is that the orthopedic team at Richland told him that if this does not heal he may need to have his foot amputated possibly, and this obviously has him concerned and he would like to get a second opinion regarding such. We will go ahead and facilitate this for him. Follow up as needed otherwise.

TERRY L NAGEL, DO

cc:

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:

Lexington Family Practice White Knoll

5535 Platt Springs Road
Lexington, South Carolina 29073

PATIENT: RUSSELL, MIKE C		VISIT DATE: 10/11/2007
PATIENT #: [redacted]	XXX-X1-7773	D: 10/11/2007 5:1 PM
PHYSICIAN: TERRY L NAGEL, DO		T:: 10/12/2007 3:50 PM / cmh
		DATE OF BIRTH: [redacted]

S: The patient is a 35-year-old white male who presents today complaining of right elbow pain and forearm pain for about the past 2 months. He works in construction, does a lot of lifting, pushing, pulling. He complains of pain over the lateral epicondyle. He states he has not tried anything other than ice, which has helped. CURRENT MEDICATIONS: None. ALLERGIES: None known. SH: Positive for smoking, drinks an occasional beer. FH: Charted. Reviewed and unchanged. ROS: As above, otherwise negative. Please see green sheet.

O: VITAL SIGNS: Weight 176, temperature 97, pulse 92, respiratory rate 20, blood pressure 140/92. GENERAL: Alert x3, no acute distress. Nontoxic appearing. HEENT: TMs clear. Nares clear. Throat clear. LUNGS: Clear. HEART: Regular rate and rhythm. ABDOMEN: Soft, nontender. EXTREMITIES: Right elbow, some mild tenderness over the lateral epicondyle area, no significant swelling. No redness or erythema. Slightly positive Mills and slightly positive Cozens sign. Neurovascular status intact. No other abnormalities could be appreciated.

A: Lateral epicondylitis.

P: Ice, massage. Rx Lodine 400 mg p.o. every 12 hours. Tennis elbow strap and wrist splint. Avoid excessive wrist extension. Recheck in a couple of weeks if not better, sooner if worse. Discussed cortisone therapy down the road if not improving.

TERRY L NAGEL, DO

cc:

PLIC 0281

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: RUSSELL,MICHAEL C
AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0000845
REPORT NO: 0102-0237

ROOM:
PT LOCATION: HED
SHAANN EM

ADMITTING DR:
ORDERING DR: ANNA S. SHALKHAM MD

REPORT STATUS: Signed

ORDERED BY: ANNA S. SHALKHAM MD
LOCATION: REG ER HEDZ2 25
STUDY TYPE: 0102-0076 RAD/CHEST 1 VIEW

DATE OF EXAM: 01/02/08

CLINICAL DATA: 35M, CHEST PAIN.

PA CHEST (1 VIEW):

FINDINGS: One PA upright projection of the chest shows clear lung fields. The cardiac and mediastinal shadows appear normal. The costophrenic angles are sharp. The bony structures are intact.

IMPRESSION: Negative PA upright chest.

SHM

DAVID N KNIGHT MD

REPORT STATUS: Signed

SHALKHAM,ANNA S. MD
ORDER#/PROCEDURE: 0102-0076 RAD/CX1 (71010)
EXAM TECH: BITHO
REP RELEASED BY: KNIDAV RAD 01/02/08 1456
ADD RELEASED BY:
DISC DATE: 01/02/08
ED DISC DIAG: BACK CONTUSION

PT LOC/ROOM: HED/

RUSSELL,MICHAEL C

PLIC 0282

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	382.00
450 EMERGENCY ROOM GENERAL	3163.00
636 DRUG SPEC ID DETAIL CODING	34.00
710 RECOVERY ROOM GENERAL	1071.00
730 EKG/ECG GENERAL	261.00
961 PROF FEES ANESTHETIST CRNA	1785.00
981 PROF FEES EMERGENCY ROOM	2289.00
986 PROF FEES EKG	72.00
Billed charges to date:	30185.99

PLEASE RETAIN THIS PORTION FOR YOUR RECORDS

INSURANCE INFORMATION

BLUE CHOICE/COMPANION ZCL3024197

QUESTIONS

BILLING QUESTIONS OR AN ITEMIZED BILL REQUEST? CALL YOUR CUSTOMER SERVICE REPRESENTATIVE AT (803)788-2300 OR (877)835-0925 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:	06/19/08
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

PAGE: 1 of 1

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 2511.90

SHOW AMOUNT PAID HERE $

6517416

0101

MICHAEL C RUSSELL

[redacted]

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555*TE90HAG5T000142

PLIC 0283

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 P08172900268	DATES OF SERVICE: 06/20/2008 - 07/01/2008
ACCOUNT BALANCE: $77,387.21	TOTAL CHARGES: $77,387.21
AMOUNT PAID: $	

STATEMENT DATE: 07/06/08 PAGE: 1 of 1

ADDRESS SERVICE

MICHAEL C RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172-2451

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 0284

IF ANY OF THE FOLLOWING IS CHANGED SINCE YOUR LAST STATEME... 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 0285

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 | 1-Interstate 2-US Primary 3-SC Primary | 4-Secondary 5-County | Collision Location (Rt. # / Name) | 6-Main Line 7-Alternate 8-Ramp | 9-Connector 10-Business | Milepost | Dir. N E S W | Nearest City or Town of

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

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
Contacted To Collision | City, State, & Zip

FR10 Audit No. X-561056 | 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
Contacted To Collision | City, State, & Zip

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
Contacted To Collision | 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: 800-842-3675
Agency Name: ON 1993 | 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

Notice of Requirement Accepted | Signature | Y N Refused to Affix Signature? | Y N Vehicle Subject to Registration in SC?

By the Completed Below or Entered at WWW.SCALIR.COM By Insurance Company Representative. This information must be mailed to DMV if insurance information has been submitted electronically.

The information contained herein is, to the best of my knowledge and belief, a correct statement of the above insurance company and its contract or policy as applied to the above described motor vehicle.

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 vehicles 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, Fleet Policy of 25 or more vehicles 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 number.
- Check here if liability insurance was not in effect to comply with South Carolina statutory requirements.

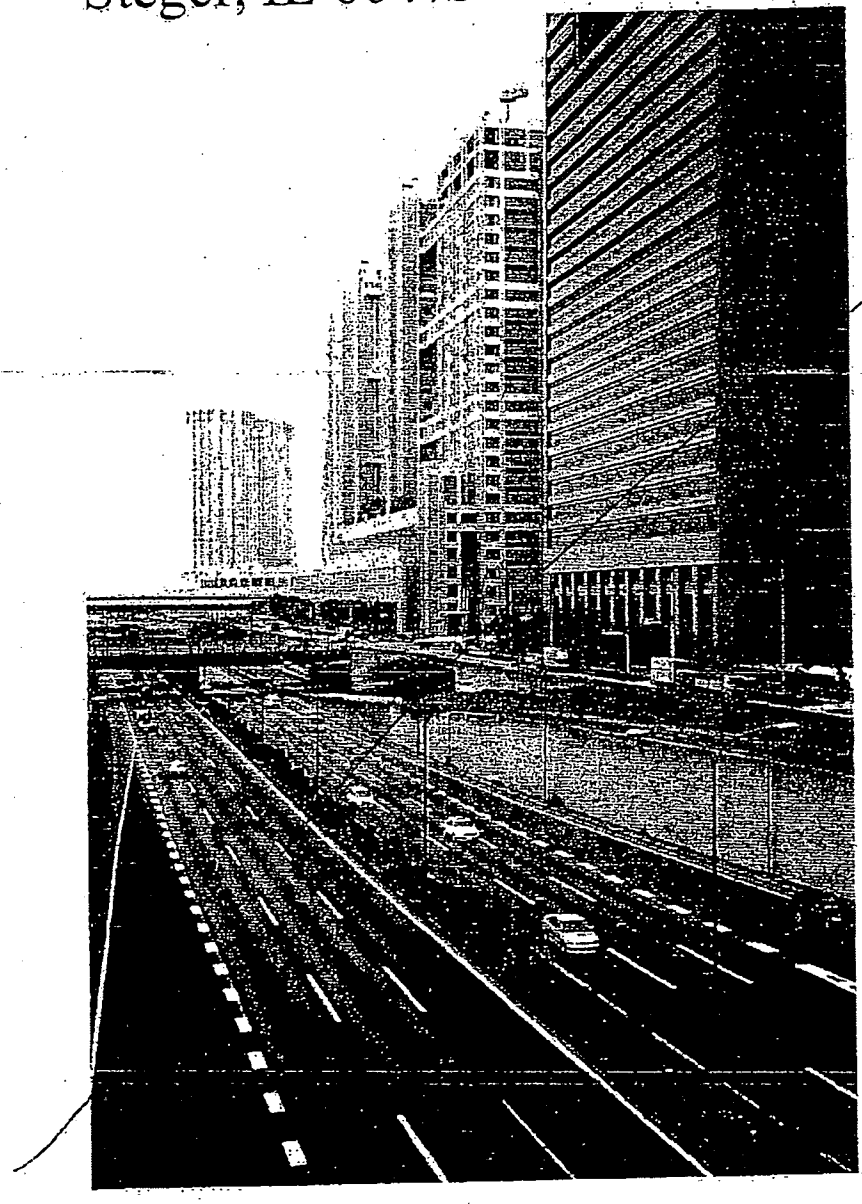
Signature | Date

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

Investigating Officer's Name | Rank | Badge # | Code | Date | Reviewer's Name | Rank | Internal Agency Code

PLIC 0286

Mike Sutton
3433 Kings Road #110
Steger, IL 60475



Returned

PLIC 0287

Field Referral

Insured: Mike Russell	Today's Date: February 12, 2009
Dependent: N/A	Benefits Paid to: 01/25/09
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: Mike Sutton
City: State: Zip:	Date Mailed: 02/12/09
Directions:	Date of Contact:

INSTRUCTIONS

Good Morning Mike,

Please see attached information on insured.

REPORT OF CONTACT

Dictation Date:

Dictation Tape No.:

TCR:

PLIC 0288

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 Company
www.pennlife.com

MAIL CENTER
8090

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
CLAIMS

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 (First) | (Middle) | Russell (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)
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 0290

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

JUL 30 2002

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 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: Install ext 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 [illegible] 2002	

[illegible] 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
04425	173416	R61						249.69

PA 1900 SC Rev. 3 6.01

PLIC 0291

FORM SERIES 1900 - ACCIDENT OR 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 / Elimination — Insured: 2 / 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	$		TOTAL MODE PREMIUM:
(Waiver of Premium will apply to any Monthly ADB Riders included)			
TOTAL PREMIUM - ALL COVERED INSUREDS Includes Inflation, Waiver and any Monthly ADB Premium	$ (INC ROP)		$ (Includes ADB premium from front)

*Disability Income, Emergency Treatment and Personal Care benefits NOT available to children

PLIC 0292

ROA 2034

COMPLETE FOR ALL COVERAGES GIVEN IN DETAILS 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 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.

Signature of Applicant _____ Signature of Spouse (if insured) _____

Lexington (City) SC (State) 7/5/02 (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

_____ 100 % 173416
Signature of Licensed Agent Agent Code

_____
Agent Printed Name

_____ _____ % _____
Signature of Licensed Agent Agent Code

Application Signed in: W. COLUMBIA, SC

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 — Agent Code 173416

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		LGLC				

P-A-300 Ed. 3-97

PLIC 0295

ROA 2037

resp inc

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 s/erp 5 2A's Income: $7500/M MIB: Yes / (No)

Life: 1904 → $400K/- Critical Care: 1946 $50/-

A&H: ACC: 500/M 4-7EP Sickness: 1903 → $750PP 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

MIB Codes: / / /

U/W: _____ Date: _____ Second Review: _____ Date: _____

UND-199 3.01

PLIC 0296

ROA 2038

/LVANIA LIFE INSURANCE COMP
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 of Licensed Agent — Agent # — 6/27/02

Signature of Licensed Agent — Agent #

Application signed at:

Columbia SC — 6/27/02

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 of Applicant

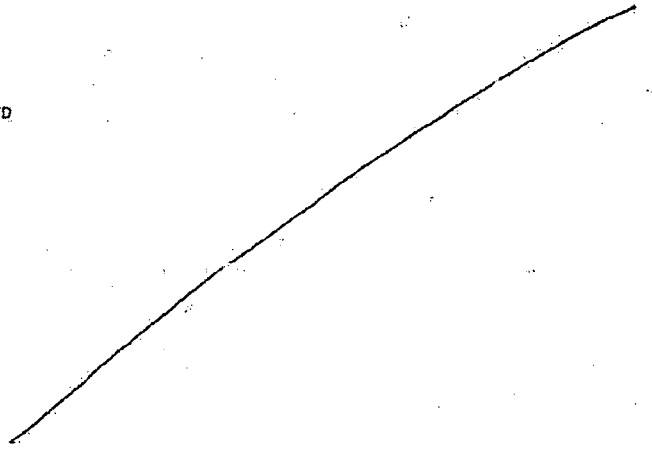
MCF-416 NC-P ED. 4-95

PLIC 0297

PA01679360 INSURED: RUSSELL,MIKE, UND: 07-10-02

544 010 R NFD
RUSSELL, MIKE
[redacted]9360
[redacted] ILL

877 001 R NFD
RUSSELL, MIKE
[redacted]9360
[redacted] ILL



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 0299

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: 02-001-001-08090000.82
	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 Ortho. Richland 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 0300

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	Lacetabulum 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 (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. 6938

Columbia, SC

PLIC 0301

ROA 2044

PLIC 0302

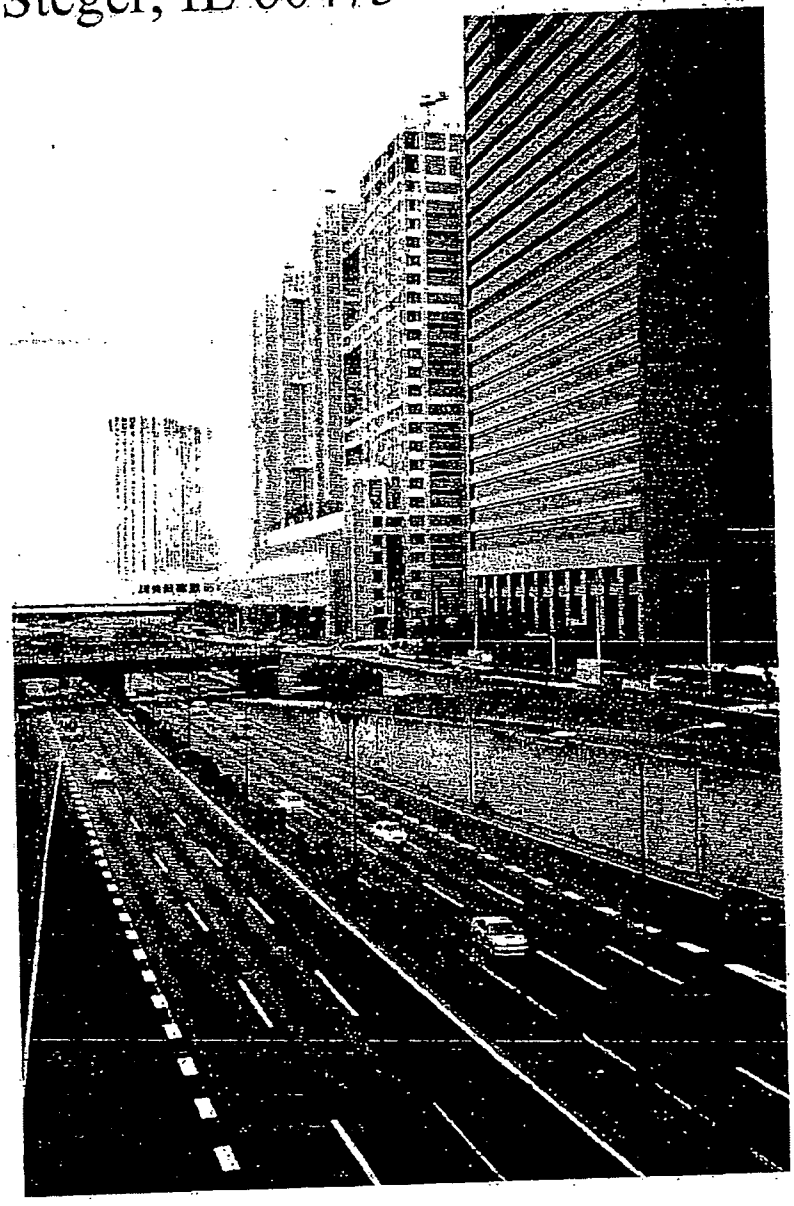
Russell

COLUMBIA SC 292
29 JAN 2009 PM 1 T

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

32591$2355

Mike Sutton
3433 Kings Road #110
Steger, IL 60475



PLIC 0303

Advisor: Ella Lee
Claim #: 0809-00062
Date: 01/29/09

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: Over the limit. Would like to pay current. Per Dr. Nagel, The fx not healing like it should. Patient is still wearing a cam walker and his crutches. Insured upset and wants to get a second opinion. He injured his leg and hip from a motorcycle accident on 06/18/08

Advisor Opinion: Pay claim current.

Reviewer recommendations:
may be good to get a write up from Dr. Nye to see his opinion on recovery time. Since payment is over $4,000 please follow over 4,000

PLIC 0304

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 1/29/09

Rus

CLAIM NUMBER: 0804-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L | REVIEW DATE | PAY TYPE
020409 | B

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED: 06/18/08
CHANGE TO:

CLC

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted]9360	0120	8090	SDD		✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
3	12	TD 1901	112508	012509			
4	12	1901	112308	012509			

MANUAL DRAFT NUMBER | BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE

PLIC 0305

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	**DATE AND TIME: January 27, 2009**
Policy Number and Policy Form: [redacted]9360	
Claimant Name: Mike Russell	
Caller Name: Advisor	
Telephone Number: 803-252-0606, 214	**Incoming? x** / **Outgoing?**
Alternate Telephone Number:	**Claim Number: 0809-00062**

NATURE OF CALL

received a call from insured wife Susanne Russell.She said the Orthopeadic surgeon refuses to fill out the scf or any paperwork for her or any of his patients. He has had the scf for two weeks now and still will not fill it out. She was wondering if we ever ran into this kind of problem and what she should do about it. She also stated her husband sees a pain management doctor as well who gives him medication, shock therapy and shots for his hip injury. She wanted to know if he could sign the scf on behalf of her husband instead. She says she does not know what to do. She is trying to be compliant but the doctor will not work with her.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

Nurse fills out Pmed form then doctor fills in the important info (ortho)
Last Appt Nov, Next FEB 23, 2009, Never even examined his surgical site. The nurse removed the staples. Can not go with someone
Make Appt w/Family Dr a few months asked for another ortho but Dr. ~~denied~~ said (p.mang)
he is already being treated and no one will want to see him.

Signature: Ella Lee — Date: 01/27/09

They wanted 2 months to see a pain med Dr.
Gives him vitamins as well, Ultra Sounds. 1/19/08 last Appt.
The Pain Dr will try to get him in w/a new ortho Doctor.
She says she spoke to Angie @ the ortho doctor.
I called Dr. office (803) 434-6958
Does fill them out just takes his time Sometimes takes months. Per Angie she gets frustrated with it too.

Advisor: Ella Lee
Claim #:
Date:

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): Please see phone note.

Question: Insured wants instruction on the scf that is to be filled out by the doctor.

Advisor Opinion: I am aware that we need the scf each month to check for progress. Maybe we can have it filled out by the pain management specialist.

Reviewer recommendations:
Does the insured have a primary that treats him in coordination with the Ortho? If not I would confirm this with the Ortho's office & have the pain mgmt doctor complete it as the Ortho should

PENNSYLVANIA LIFE INSURANCE CO.

January 13, 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

Enclosure

cc: File

PO Box 12355, Pensacola, FL 32591 • (Tel) 1-888-399-8847 (Fax) 1-850-432-6077

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
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
DEPENDENT-

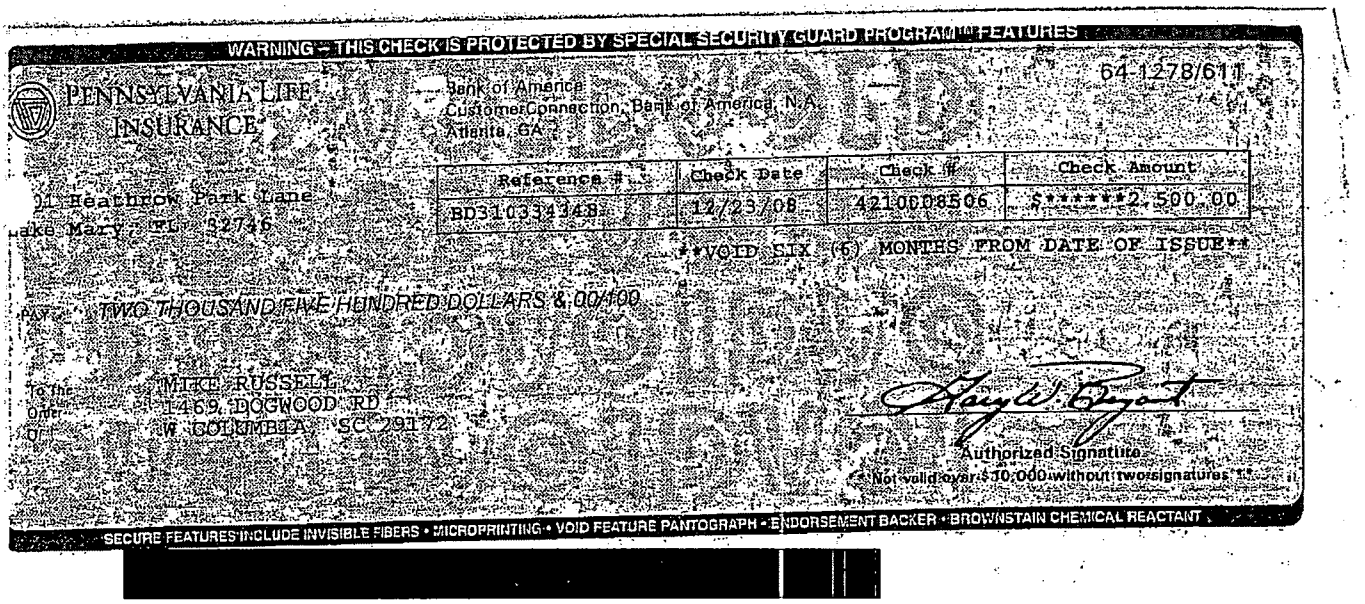
POLICY NO. [redacted]9360 DATE PAID 12-23-08
CLAIM NO. 0809-00062 REP ID. BD310334348

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 0309



WARNING - THIS CHECK IS PROTECTED BY SPECIAL SECURITY GUARD PROGRAM™ FEATURES

PENNSYLVANIA LIFE INSURANCE

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310334348	12/23/08	4210008506	$*****2,500.00

01 Heathrow Park Lane
Lake Mary, FL 32746

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY TWO THOUSAND FIVE HUNDRED DOLLARS & 00/100

To The Order Of MIKE RUSSELL
1469 DOGWOOD RD
W COLUMBIA, SC 29172

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

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210008506
CHECK DATE 12/23/08

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 12-23-08
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

12750

PLIC 0310

01-28-09;03:48PM; # 1/ 2

8090

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.

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 30	Claim No: 02-001-001-080900052
	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 & Richland 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:

RECEIVED
JAN 28 2009
DISABILITY CLAIMS
PENSACOLA

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 0311

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
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. 3-05

PLIC 0312

ATTENDING PHYSICIANS STATEMENTS

408 MacDade Blvd
Collingdale, PA 19023
Telephone (610) 534-5424
Fax (888) 550-5424

" Automation in Electronic Medical Data Retrieval "

Order #: 660873

Insurance Company: Pennsylvania Life Insurance

Medical Records received on: 12/5/2008

Policy Number: [redacted]9360

Patient's Information

MICHAEL RUSSELL

DOB: [redacted]
SSN:

Provider's Information

DR. JOHN LAQUINTO
3 MEDICAL PARK DRIVE, SUITE 330
COLUMBIA, SC 29203
Phone: 803-434-6958
Fax: 803-434-8537

Facility:

Dates of service requested: Last Five (5) Years.

Thank you, and we sincerely appreciate your business!
Attending Physicians Statements

The following records are pages submitted to our office by the above referenced provider.

PLIC 0313

******* INSTANT BILL *******
PREMIER ORTHOPEDIC SPECIALISTS
PO BOX 402145
ATLANTA, GA 30384-2145

Office PH:(803) 434-8354 Home Ph:

MICHAEL C RUSSELL

ACCT: [redacted] Date: 12/05/08

Last Pmt
11/12/08 $20

Work Ph:

PAT NAME
--- ----------
0 MICHAEL [redacted]

DIAGNOSIS CODES

1 - 823.92
2 - 808.0
3 - 835.01
4 - 823.01
5 - MR

DOCTORS

1 - John Iaquinto

STATE ID

EMPL ID [redacted]

SERVICE DATE	DATE POSTED	PAT NUM	D R	D G	PROC	MOD	DESCRIPTION	CHG/PMT
06/24/08	07/15/08	0	1	1	27759		OPEN TX TIB FX BY IMPL W/	3390.00
06/24/08	07/15/08	0	1	2	27226	22	OPEN TX POST/ANT ACETAB F	2997.00
06/24/08	07/15/08	0	1	3	20650		INSRT WIRE/PIN W/TRAC-SEP	361.00
07/14/08	07/17/08	0	1	4	99024		POSTOP F/U VISIT INCL GLO	.00
08/11/08	08/12/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
08/29/08	08/29/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	15.00
08/29/08	08/29/08				PMT		Check from Other-atty	-15.00
06/24/08	09/09/08				PMT		Other from Patie-oc sg	-20.00
09/22/08	09/25/08	0	1	2	99024		POSTOP F/U VISIT INCL GLO	.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	09/30/08				ADJ		Timely Filing Adj	-361.00
11/03/08	11/04/08	0	1	2	99212		OFC/OUTPT E&M ESTAB MINOR	67.00
11/10/08	11/12/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	20.00
06/24/08	11/12/08				ADJ		Companion Adj	3370.00
06/24/08	11/12/08				ADJ		Companion Adj	2997.00
06/24/08	11/12/08				ADJ		Companion Adj	361.00
11/10/08	11/12/08				PMT		Other from Patie-	-20.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-361.00
							Total	$67.00

REF PHYS : ,

TAX ID:

PLIC 0314

******* INSTANT BILL *******
PREMIER ORTHOPEDIC SPECIALISTS
PO BOX 402145
ATLANTA, GA 30384-2145

ACCT: [redacted] Date: 12/05/08

Last Pmt
11/12/08 $20

Office PH:(803) 434-8354 Home Ph:(803) 955-0329 Work Ph:(

MICHAEL C RUSSELL

PAT NAME	
0	MICHAEL

[redacted]

DIAGNOSIS CODES

1 - 823.92
2 - 808.0
3 - 835.01
4 - 823.01
5 - MR

DOCTORS

1 - John Iaquinto

STATE ID

EMPL ID [redacted]

SERVICE DATE	DATE POSTED	PAT NUM	D R	D G	PROC	MOD	DESCRIPTION	CHG/PMT
06/24/08	07/15/08	0	1	1	27759		OPEN TX TIB FX BY IMPL W/	3390.00
06/24/08	07/15/08	0	1	2	27226	22	OPEN TX POST/ANT ACETAB F	2997.00
06/24/08	07/15/08	0	1	3	20650		INSRT WIRE/PIN W/TRAC-SEP	361.00
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06/24/08	09/30/08				ADJ		Timely Filing Adj	-3370.00
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06/24/08	09/30/08				ADJ		Timely Filing Adj	-361.00
11/03/08	11/04/08	0	1	2	99212		OFC/OUTPT E&M ESTAB MINOR	67.00
11/10/08	11/12/08	0	1	5	99080		SPEC REPORT >INFO IN USUA	20.00
06/24/08	11/12/08				ADJ		Companion Adj	3370.00
06/24/08	11/12/08				ADJ		Companion Adj	2997.00
06/24/08	11/12/08				ADJ		Companion Adj	361.00
11/10/08	11/12/08				PMT		Other from Patie-	-20.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-3370.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-2997.00
06/24/08	11/13/08				ADJ		Timely Filing Adj	-361.00
							Total	$67.00

REF PHYS : ,

TAX ID:

PLIC 0315

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 11/03/2008 DOB:

11/03/2008

ATTENDING PHYSICIAN: John M. Jaquinto, MD

HISTORY OF PRESENT ILLNESS: Patient's date of injury was 06/18/2008. He is status post ORIF of his left acetabulum, IM rod of his left open tibia. He comes in today on 11/03/2008. He states he is having pains in his hip, knee, and ankle. He is ambulating with his left lower extremity approximately 3 to 4 hours a day. Today with the cold and rainy-type day, he states he is having a lot of pain in his hip.

PHYSICAL EXAM: We can internally and externally rotate at the hip, flex, and extend although this does cause him some discomfort. He can flex his knee past 90, do a straight-leg lift, and dorsiflex and plantar flex his toes. All the surgical wounds have healed. He is neurovascularly intact. Skin is warm, dry, and intact. No sign of infections. No drainage from any of his wounds.

LABORATORY DATA/IMAGING: X-rays reviewed with Dr. Iaquinto show some traumatic arthritis at the left hip and minimal healing, but well aligned left tibia.

ASSESSMENT: The patient is status post open reduction, internal fixation of left acetabulum and intramuscular rodding of his left open tibia fracture.

PLAN: Patient given Celebrex 200 mg 1 p.o. b.i.d. for his arthritic pain. He is given a referral for Pain Clinic for some chronic pain of his hip. He will follow up in 16 weeks. We will get AP and lateral of his left tibia. We had a discussion with the patient and his wife that if the tibia still continues not to heal, when he returns in 4 weeks we may need to talk about further surgery to his tibia. Again, we reiterated that the patient needs to stop smoking. All other questions were answered. He does not need to wear his Cam Boot walker anymore. He may walk on the leg as pain allows; crutches or cane at his discretion. We will see the patient back in 16 weeks.

John M Iaquinto, MD

Dictated by: Michael D. Richards, PA-C

MR:th
D: 11/03/2008 1:56 P T: 11/03/2008 4:31 P
Job #: 00023222 T Job #: 40223777 Doc #: 1280293
cc:

Original

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 09/22/2008 DOB:

09/22/2008

ATTENDING PHYSICIAN: John M. Iaquinto, MD

OFFICE NOTE

HISTORY: Mr. Russell is status post a left acetabulum and IM rodding of his grade IIIA open left tibia. The patient comes in today. He is 3 months out from his surgery. He has complaints of when he is standing up straight he gets pain in the muscles going from his buttocks down to the lateral side of his knee. As long as he is not standing up straight, he does not have any pain in his leg in this area. Denies numbness or tingling. He has no pain with range of motion of the left hip or in the seated position.

PHYSICAL EXAMINATION: On exam, I can internally-externally rotate at the hip without causing any pain. He can flex and extend without any pain. When we had him stand up, he could reproduce the pain that he gets running down the lateral side of his leg. He is able to dorsiflex and plantarflex his foot. He is neurovascularly intact. His surgical wounds have healed. His open wound on his left tibia has healed. X-rays reviewed with Dr. Iaquinto.

ASSESSMENT: The patient is status post intramedullary rod of his left open tibia, open reduction and internal fixation of his left acetabulum.

PLAN: Again, reiterated that the patient needs to stop smoking. He still smokes over a pack per day. He wants his open tibia fracture to heal. Hopefully, he can stop smoking. We will allow him to increase his weightbearing to weightbearing as tolerated as long as he keeps the Cam boot walker on. He states that he has done well ambulating with the Cam boot on.

Original

PALMETTO HEALTH ORTHOPEDICS
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-6958

Does not have any pain in his tibia. When he returns in 6 weeks, we will get an AP/lateral of his left tibia, AP pelvis, and he was given Tylenol. No. 3 one to 2 q 8 hours, #60. Discussed with patient this will be his last refill. We will not call any more pain medications in at this time.

John Iqauinto, MD

Dictated by: Michael D. Richards, PA-C

MR:fa
D: 09/22/2008 1:37 P T: 09/23/2008 12:00 P
Job #: 000284190 T Job #: 40138412 Doc #: 1260235
cc:

PATIENT: Russell, Michael

OUTPATIENT CONSULTATION REPORT

Original

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803)434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russell, Michael MR#:
VISIT DATE: 08/11/2008 DOB:

08/11/2008

ATTENDING PHYSICIAN; John M. Iaquinto, MD

SUBJECTIVE: Returns for scheduled follow up now about seven weeks status post ORIF left acetabulum and IM nail left tibia. Pain control is improving steadily. He still has pills left from the most recent prescription.

OBJECTIVE: X-ray left acetabulum shows unchanged satisfactory fracture reduction and implant position. X-ray left tibial similarly shows unchanged satisfactory fracture reduction and implant position.

EXAM: Left lower extremity good sitting posture. Flexion symmetrical to the normal right side. Extension within about 20 degrees of full extension. Noticeable quadriceps atrophy. All wounds and incisions well healed and benign. Moderate foot swelling.

ASSESSMENT: Healing left acetabulum and tibia shaft fracture.

PLAN: Initiate partial weight bearing about 25%-30% body weight on the left and initiate home quadriceps exercise program and hip abductor strengthening program.

ROV: Six weeks for exam, x-ray left tibia.

Original

PALMETTO HEALTH ORTHOPEDICS
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-6958

John Iaquinto, MD

JMI:fn
D: 08/11/2008 1:40 P T: 08/12/2008 2:36 P
Job #: 000209485 T Job #: 40101145 Doc #: 1240383
cc:

PATIENT: Russell, Michael

OUTPATIENT CONSULTATION REPORT

Original

PREMIER ORTHOPEDIC SPECIALISTS
3 Medical Park Drive, Suite 330
Columbia, SC 29203
(803) 434-6958
Fax (803) 434-8537

OUTPATIENT VISIT

PATIENT: Russel, Michael MR#:
VISIT DATE: 07/14/2008 DOB:

ATTENDING: John M. Iaquinto, MD.

SUBJECTIVE: Three weeks status post ORIF of left acetabulum posterior wall fracture/dislocation and IM nail and debridement of the open left tibial fracture. Reports pain is tolerable.

OBJECTIVE: X-ray of left acetabulum and pelvis shows satisfactory fracture reduction with satisfactory implant position, maintained with a congruent hip joint. X-ray of left tibia shows satisfactory fracture reduction with satisfactory implant position.

Left lower extremity flexion to 90, extension to about 45, all atraumatic wounds, and the incision is benign and well healed with mild scabbing.

ASSESSMENT: Left acetabulum fracture and left open tibia fracture.

PLAN: Focus on re-extension. I discussed physical therapy, but he feels he will be able to do this on his own. ROV 4 weeks for exam; x-ray left tibia. Continue toe-touch weightbearing.

John Iaquinto, MD

JMI:hs
D: 07/14/2008 2:06 P T: 07/15/2008 10:44 A
Job #: 000161479 T Job #: 742888 Doc #: 1227377
cc: John M. Iaquinto, MD

Original

Operative Report

RUSSELL, MICHAEL C - [redacted]

Result type: Operative Report
Result date: 24 June 2008 14:03
Result status: Transcribed
Result title: Operative Report
Performed by: Iaquinto MD, John M on 24 June 2008 14:03
Encounter info: [redacted] Richland; IPR-Inpatient, 06/20/08 - 07/01/08

Operative Report
DATE OF OPERATION: 06/24/2008

DATE OF SURGERY: June 24, 2008

PREOPERATIVE DIAGNOSES:
1. Fracture dislocation left acetabulum posterior wall.
2. Grade 3a open tibia fracture, left.

POSTOPERATIVE DIAGNOSES:
1. Fracture dislocation left acetabulum posterior wall.
2. Grade 3a open tibia fracture, left.

OPERATIVE PROCEDURE:
1. Removal of traction pin from left tibia following previous insertion of tibial traction pin left tibia and intramedullary nail left tibia fracture - CPT code 27759.
2. Open reduction, internal fixation left acetabulum fracture - CPT code 27226.

SURGEON: John M. Iaquinto, MD

ATTENDING: John M. Iaquinto, MD

ANESTHESIA: General endotracheal.

ESTIMATED BLOOD LOSS: 300 mL.

SPECIMEN: Multiple osteochondral fragments from left acetabulum.

COMPLICATIONS: None.

INDICATIONS: Unstable long bone fractures, open, and fracture dislocations of weightbearing joints requiring open anatomic reduction and stable internal fixation for optimal patient outcome.

DESCRIPTION OF OPERATION: Following the achievement of adequate general anesthesia, the patient was removed from traction and the small wire tibial traction pin was cut and removed without difficulty under sterile conditions. The patient was transferred to a radiolucent OSI table in

Operative Report RUSSELL, MICHAEL C - [redacted]

supine position and tourniquet applied to the left thigh and then splint removed from the left leg. The traumatic wound was noted to be benign and the fracture was noted to be grossly unstable. A tourniquet was applied to the left thigh and the left lower extremity prepped and draped in normal sterile orthopedic manner, exsanguinated by elevation and tourniquet inflated to 300 mmHg. The knee was placed over a triangle and a medial parapatellar incision made and carried down through the subcutaneous tissue. Entry portal site identified and an entry portal made and guidepin inserted and then an entry portal made with a rigid reamer. Guidepin passed antegrade down the proximal fragment across the fracture site and into a satisfactory position in the distal tibia. The tibial canal was then reamed in 0.5 mm increments from 9 to 11 mm and then a 10 mm x 30 mm Synthes tibia nail was inserted to an appropriate depth without difficulty. Cross-locking with 1 screw was accomplished utilizing freehand technique. The fracture site was impacted with backslaps on the driver and then proximal cross-locking with 1 screw was accomplished utilizing the proximal cross-locking guide. The operative incision was then closed in layers with staples on the skin. A sterile dressing was applied.

The patient was then transferred to the right lateral decubitus position on the beanbag and a new prep and drape of the left hip area was carried out. A longitudinal lateral incision made and carried down through the subcutaneous tissue. Fascia lata identified and divided in line with the incision. The gluteus maximum fibers were bluntly divided in line with the incision. Piriformis tendon identified, transected at its insertion and retracted. Sciatica identified, preserved and protected throughout the procedure. There was extensive soft tissue damage in the superior-posterior aspect in the area of the posterior wall fragment. The posterior wall was noted to be more extensively damaged than a typical posterior wall and was noted to be segmentally fractured into 3 pieces with multiple loose osteochondral fragments and multiple 1 cm diameter marginal impaction fragments which were elevated, but unable to be stabilized adequately and were removed for specimen. The femoral head also was noted to have a large sheared cartilage fragment. The wound was then copiously irrigated with normal sterile saline and then the head was reduced and then the segments of the posterior wall in succession were reduced and stabilized with smooth pins. These were then fixed with interfragmentary screws and then intraoperative image demonstrated satisfactory fracture reduction, satisfactory screw placement and then a 9-hole 3.5 mm pelvic reconstruction plate was then bent appropriately and screws were drilled, measured and inserted in succession. Following this, intraoperative biplane imaging demonstrated satisfactory fracture reduction and satisfactory implant position with the congruent hip joint. The wound was copiously irrigated. Piriform tendon repaired to its insertion and hip joint capsule repaired and then fascia lata repaired with interrupted #1 Vicryl sutures. A sterile dressing was applied. Sponge, instrument and needle counts were taken and found to be correct. The patient tolerated the procedure well and arrived to the recovery room in satisfactory condition.

Operative Report

RUSSELL, MICHAEL C [redacted]

JMI:hs
D: 06/24/2008 1:19 P T: 06/24/2008 2:03 P
Job #: 000138205 T Job #: 432112 Doc #: 1217761
cc:: John M. Iaquinto, MD

Completed Action List:
* Perform by Iaquinto MD, John M on 24 June 2008 14:03

ATTENDING PHYSICIANS STATEMENTS

408 MacDade Blvd
Collingdale, PA 19023
Telephone (610) 534-5424
Fax (888) 550-5424

"Automation in Electronic Medical Data Retrieval"

Order #: 660874

Insurance Company: Pennsylvania Life Insurance

Medical Records received on: 12/12/2008

Policy Number: [redacted]9360

Patient's Information

MICHAEL RUSSELL

DOB: [redacted]
SSN:

Provider's Information

DR. TERRY NAGEL
5535 PLATT SPRINGS ROAD,
LEXINGTON, SC 29073
Phone: 803-951-1880
Fax: 803-951-0384

Facility: LEXINGTON FAMILY PRACTICE

Dates of service requested: Last Five (5) Years.

Thank you, and we sincerely appreciate your business!
Attending Physicians Statements

The following records are pages submitted to our office by the above referenced provider.

Lexington Family Practice White Knoll

Name: Mike Russell DOB: [redacted]

Chart #: [redacted]

Vital Sign / Flow Sheet

Date	Temp	PR/RR	BP	Ht/Wt	Chief Complaint	Pain	Initials
N 10-7-08	98	94 20	132/74	180	36 Needs referral - Ortho	Yes	YB
			6/18		no pain meds	Yes	
					non rads	Yes	
					compound fx	Yes	
					(L) tib/fib	Yes	
					Acetabulum fx	Yes	
	Numbness					Yes	
					ortho referral	Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	
						Yes	

8360-011-1 (05/06)

PLIC 0326

Lexington Family Practice White Knoll

Name: Mike C. Russell DOB: [redacted]

Chart #: [redacted]

Vital Sign / Flow Sheet

Date	Temp	PR/RR	BP	Ht/Wt	Chief Complaint	Pain	Initials
N 10/11/09	97.0	92/20	144/92	172#	(M) (35) C/O TI MONTH O.F (N) FALL	Yes	
					↑ C ATTEMPING TO LIFT US FLEXIBLE	Yes	
(N) 01/04/08	97.5	88/16	128/82	165#	(M) 35 PT FELL & HIT [redacted] MID (L) [redacted]	Yes	
					CORNER OF TABLE. STAT @ [redacted]	Yes	
					STILL HAVE PAIN @ OF (C) S [redacted]	Yes	
					SLEEPING TAD 6	Yes	
						Yes	
						Yes	
						Yes	
						Yes	

8360-011-1 (05/06)

Lexington Family Practice White Knoll

5535 Platt Springs Road
Lexington, South Carolina 29073

PATIENT: RUSSELL, MIKE C			VISIT DATE: 10/07/2008
PATIENT #: [redacted]		XXX-XI-7773	D: 10/07/2008 4:0 PM
PHYSICIAN: TERRY L NAGEL, DO			T: 10/08/2008 5:19 PM / bil
			DATE OF BIRTH: [redacted]

S: Patient is a 36-year-old white male who presents requesting referral to orthopedics to have a second opinion. He was involved in a motor vehicle accident involving his motorcycle on 06/18/2008, where the car in front of him stopped, and he rear-ended the back of the car. This happened at 126 near exit 115. He was originally seen at Lexington Medical Center, was there for several days, and the orthopedic guys there transferred him over to Richland, where he subsequently had repair of what sounds to be a TIB/FIB fracture, left lower leg, and also had an acetabular fracture. This was repaired by Dr. Iaquinto. Patient just saw him on 10/06/2008. It was actually one of his assistants who recommended that he start bearing weight, but that the TIB/FIB fracture is not healing as it should. Patient is confused and questions if he should put full weight on this leg, given that it is not healing. Because of this he is requesting second opinion from another orthopedic doctor. He does wear a cam walker and has crutches now. CURRENT MEDICATIONS: Tylox. ALLERGIES: None known. ROS: As above; otherwise negative.

O: VITAL SIGNS: Stable; afebrile. Please see enclosed in chart. GENERAL: Alert x3, in no acute distress, nontoxic-appearing. LEFT LOWER EXTREMITY: Post-op surgical changes, some slight swelling in lateral aspect of lower leg.

A: Nonhealing TIB/FIB fracture.

P: Referral to orthopedics for second opinion, per patient's request. His main concern is that the orthopedic team at Richland told him that if this does not heal he may need to have his foot amputated possibly, and this obviously has him concerned and he would like to get a second opinion regarding such. We will go ahead and facilitate this for him. Follow up as needed otherwise.

TERRY L NAGEL, DO

cc:

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:

Lexington Family Practice White Knoll

5535 Platt Springs Road
Lexington, South Carolina 29073

PATIENT: RUSSELL, MIKE C			VISIT DATE: 10/11/2007
PATIENT #: [redacted]		XXX-XX-7773	D: 10/11/2007 5:1 PM
PHYSICIAN: TERRY L NAGEL, DO			T: 10/12/2007 3:50 PM / cmh
			DATE OF BIRTH: [redacted]

S: The patient is a 35-year-old white male who presents today complaining of right elbow pain and forearm pain for about the past 2 months. He works in construction, does a lot of lifting, pushing, pulling. He complains of pain over the lateral epicondyle. He states he has not tried anything other than ice, which has helped. CURRENT MEDICATIONS: None. ALLERGIES: None known. SH: Positive for smoking, drinks an occasional beer. FH: Charted. Reviewed and unchanged. ROS: As above, otherwise negative. Please see green sheet.

O: VITAL SIGNS: Weight 176, temperature 97, pulse 92, respiratory rate 20, blood pressure 140/92. GENERAL: Alert x3, no acute distress. Nontoxic appearing. HEENT: TMs clear. Nares clear. Throat clear. LUNGS: Clear. HEART: Regular rate and rhythm. ABDOMEN: Soft, nontender. EXTREMITIES: Right elbow, some mild tenderness over the lateral epicondyle area, no significant swelling. No redness or erythema. Slightly positive Mills and slightly positive Cozens sign. Neurovascular status intact. No other abnormalities could be appreciated.

A: Lateral epicondylitis.

P: Ice, massage. Rx Lodine 400 mg p.o. every 12 hours. Tennis elbow strap and wrist splint. Avoid excessive wrist extension. Recheck in a couple of weeks if not better, sooner if worse. Discussed cortisone therapy down the road if not improving.

TERRY L NAGEL, DO

cc:

RADIOLOGY DEPARTMENT
LEXINGTON MEDICAL CENTER
WEST COLUMBIA, SC 29169
PHONE: (803) 791-2460

PATIENT: RUSSELL,MICHAEL C
AGE: 35
DOB: [redacted]
SEX: M

UNIT/MR NO: [redacted]
ACCT NO:
SSN:
REQ NO: 08-0000845
REPORT NO: 0102-0237

ROOM:
PT LOCATION: HED
SHAANN EM

ADMITTING DR:
ORDERING DR: ANNA S. SHALKHAM MD

REPORT STATUS: Signed

ORDERED BY: ANNA S. SHALKHAM MD
LOCATION: REG ER HEDZ2 25
STUDY TYPE: 0102-0076 RAD/CHEST 1 VIEW

DATE OF EXAM: 01/02/08

CLINICAL DATA: 35M, CHEST PAIN.

PA CHEST (1 VIEW):

FINDINGS: One PA upright projection of the chest shows clear lung fields. The cardiac and mediastinal shadows appear normal. The costophrenic angles are sharp. The bony structures are intact.

IMPRESSION: Negative PA upright chest.

SHM

DAVID N KNIGHT MD

REPORT STATUS: Signed

SHALKHAM,ANNA S. MD
ORDER#/PROCEDURE: 0102-0076 RAD/CX1 (71010)
EXAM TECH: BITHO
REP RELEASED BY: KNIDAV RAD 01/02/08 1456
ADD RELEASED BY:
DISC DATE: 01/02/08
ED DISC DIAG: BACK CONTUSION

PT LOC/ROOM: HED/

RUSSELL,MICHAEL C

PLIC 0331

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 12/23/08

Rus

CLAIM NUMBER: 0809-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME:

SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L | REVIEW DATE | PAYTYPE: B

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED: 06/18/08
CHANGE TO:

POLICY [redacted]9360 | NATURE 0120 | ADJUSTOR 8090 | REVIEWER | AUDITOR | PART ✓ | FINL | ADDL | REOP | CWFP | PSIE | RESC | DECLINE D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	112	TD	10/25/08	11/25/08			
4	112	TD	10/25/08	11/25/08			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL: 2500

SPECIAL MESSAGE

PLIC 0332

PENNSYLVANIA LIFE INSURANCE CO.

December 23, 2008

Mike Russell

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

Dear Mr. Russell:

To assist in our evaluation of your claim, further information is required. Please provide our office with the following information at your earliest convenience.

- Answer all questions on the Self Employed form.

A self-addressed envelope is enclosed for your use.

If you have any questions, please contact this office at 1-800-275-7366.

Sincerely,

Ella Lee
~~Job Title~~
Claims Department

cc: 000000

PENNSYLVANIA LIFE INSURANCE CO.

Self-employed Job Description

Name: Mike Russell

Policy #: [redacted]9360 Claim #: 0809-00062

Business name: _____

Business address: _____

Business telephone #: _____ Fax #: _____

Type of business: _____

Prior monthly income, after expenses: _____ Average weekly hours: _____

IMPORTANT: When completing this questionnaire, please refer only to the duties that you were performing PRIOR to your loss of06/18/08.

1. In an 8-hour workday, you stand for:

(Hours at one time)				(Total hours during day)				
☐	☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-6	6-8	0-2	2-4	4-6	6-8	8 +

2. In an 8-hour workday, you walk for:

(Hours at one time)				(Total hours during day)				
☐	☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-6	6-8	0-2	2-4	4-6	6-8	8 +

3. In an 8-hour workday, you sit for:

(Hours any one time)				(Total hours during day)				
☐	☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-6	6-8	0-2	2-4	4-6	6-8	8 +

4. In an 8-hour workday, you operate a car/truck for:

(Minutes at one time)		(Hours at one time)			
☐	☐	☐	☐	☐	☐

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10-30 30-60 1-3 3-5 5-8 8 +

5. In an 8-hour workday, you are required to lift/carry:

Maximum lbs.: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 or above

Frequently: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Occasionally: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

6. In an 8-hour workday, you are required to use your hands for repetitive:

	A. Simple Grasping	B. Pushing & Pulling	C. Fine Manipulation
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. In an 8-hour workday, you are required to:

	Continuously	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐	☐
B. Squat	☐	☐	☐	☐
C. Kneel	☐	☐	☐	☐
D. Climb	☐	☐	☐	☐
E. Crawl	☐	☐	☐	☐
F. Reach above shoulder level	☐	☐	☐	☐

8. Supervisory/Administrative Duties. Give a clear indication of the amount of time spent such as supervising, clerical, bidding work, scheduling, payroll, etc.

_____

_____

_____

9. Number of employees: Part-time _____ Full-time _____

10. When did you complete your last contract/assignment? Date: _____

11. Please provide a list of all contracts/assignments you held during the 2-month period prior to your date of loss. Please include complete contact information for all contracts.

_____
_____
_____
_____
_____
_____
_____

12. Does your business close down for any period during the year? _____

If yes, please provide dates. From: _____ To: _____

Why? _____

13. Does the weather affect your business? _____ If yes, please explain.

_____
_____

14. Please provide a detailed summary of your daily occupational job duties.

_____
_____
_____

15. Please provide a list of any licenses/certifications required to perform your job.

_____
_____
_____

16. Previous Education, Training and Experience

_____
_____
_____

17. Please sign and date your response.

_____

Signature _____ Date _____

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000-0000

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	803-955-0329	Age:	Claim No: 02-001-001-080900062
	Cell		36	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?
   John Esquinto - 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

ADDRE

C-3 R

Rev. 4-97

PLIC 0338

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 0339

Russell

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02 1P $ 000.42⁰
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PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591$2355 B012

ROA 2082

PLIC 0340

PENNSYLVANIA LIFE INSURANCE CO.

December 3, 2008

Mike Russell

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

Dear Mr. Russell:

Your claim is currently being reviewed.

We are currently obtaining medical records from Dr. Laquinto and Dr. Nagel pertaining to this claim. We are continuing our efforts and will keep you informed as the claim progresses.

Thank you for your continued patience. 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

If submitting this order, fax to 888-550-5424.

Request # 660874 contains the following data:

Patient's Information

Policy* [redacted]9360 **Date*** 12/3/2008 **SSN** [redacted]

LastN RUSSELL **MI** **FirstN** MICHAEL **DOB** [redacted]

Addr **City** **State** **Zip**

AreaCode 803 **Phone**

Special Instructions:

Original Provider Information

Atten MEDICAL RECOR **Name** DR. TERRY NAGEL

Addr 5535 PLATT SPRINGS **Addr2**

City LEXINGTON **State** SC **Zip** 29073

AreaCd 803 **Phone** 791-3494 **Ext** **Fax**

Additional Functions

☐ **Same Address Only** ☐ **Same Provider Only** ☐ **New Policy#** Add Spouse

Add request with a different provider: ☐ **New Policy#** Add Additional APS

Attach a File to this APS

Browse...

Save Attached File

Send E-mail to: ---------- Please select one ----------

To download file, click here.

Edit This Request | Cancel This Request | Go Back

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PLIC 0343

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

Russell

UNITED STATES POSTAGE
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02 1P $ 000.42⁰
0002797927 NOV 19 2008
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PENNSYLVANIA LIFE INSURANCE CO.
PO Box 12355
Pensacola, FL 32591-2355

32591+2355

ROA 2087

PLIC 0345

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 11-14-08
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 B090 STATE 38 S/C 0044413 M/C 091477

PLIC 0346

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: 11/13/08

Ros

CLAIM NUMBER: 0809-00062

CSIE | CNCO | SEE CLAIM NUMBER

DATE INCURRED: 06/18/08
CHANGE TO:

POLICY: [redacted]9360 | NATURE: 01 20 | ADJUSTOR: 8090 | REVIEWER | AUDITOR | PART | FINL | ADDL | REOP | CWFP | PSIE | RESC | DECLINE: D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
3	12	TD	092508	102508			
4	12	TD	092508	102508			

MANUAL DRAFT NUMBER | BD | DRAFT DATE | DRAFT TOTAL: 1509

SPECIAL MESSAGE

PLIC 0347

PENNSYLVANIA LIFE INSURANCE CO.

November 13, 2008

Mike Russell

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

Dear Mr. Russell:

In reviewing your claim, we notice the information requested from you in our letter of 10/8/08, has not yet been received. Enclosed is a copy of that letter for your review.

This information is important for our handling of your claim; therefore we request that you respond as soon as possible.

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

(W) 852-0002 (Wife)

8052

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	Home	803-955-0329	Age:
	~~Work~~ Cell	803-513-0575	

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?
   John Izquierdo - Premier Orthopaedic 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: _____

Rev. 4-97

PLIC 0349

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 (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	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.) 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 0350

Russell

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.42⁰
0002797927 NOV 10 2008
MAILED FROM ZIP CODE 29204

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

32591$2355 6012

ROA 2093

PLIC 0351

PENNSYLVANIA LIFE INSURANCE CO.

November 3, 2008

Mike Russell

[redacted]

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

Dear Mr. Russell:

In reviewing your claim, we notice the information requested from you in our letter of 10/08/08 has not been received. Enclosed is a copy of that letter for your review.

In addition, enclosed is a copy of the supplemental claim form. You and your doctor should answer all questions and return the form to our office.

This information is important for our handling of your claim; therefore we request that you respond as soon as possible.

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

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	DATE AND TIME: October 27, 2008: 10:15 am
Policy Number and Policy Form: [redacted]9360	
Claimant Name: Mike Russell	
Caller Name: Advisor	

Telephone Number:	Incoming? x	Outgoing?
Alternate Telephone Number:	Claim Number: 0809-00062	

NATURE OF CALL

Received a return call from insured. I wanted to check his progress:
How are you doing? Still sore
When was the last time you went to the doctor? Four weeks ago. I have another appointment next Monday.
Has the dr. given you an estimated time to return you to work? He has a compound fracture that will not heal and the muscle in his hip is still sore. They have not given him a date.
What care is your dr. currently providing? PT twice a week, has not determined how long that will be
Do you have any other insurance? No, I am looking for a second opinion because I am not satisfied with my current doctor but it is hard trying to get a second opinion.
I asked him if he had a scf on hand? Yes.
Please fill out the front entirely and have your doctor complete the back. He said ok.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

Signature: Ella Lee E.L.	Date: 10/27/08

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mr Ron Russell

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER | L | REVIEW DATE | PAY TYPE: B

DATE: 10/8/08

Rus

CLAIM NUMBER: 0809-00062

CSIE	CNCO
SEE CLAIM NUMBER	

DATE INCURRED: 6/18/08
CHANGE TO:

POLICY	NATURE	ADJUSTOR	REVIEWER	AUDITOR	PART	FINL	ADDL	REOP	CWFP	PSIE	RESC	DECLINE
[redacted]9360	8090	8090			✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	OR
2	12	TTD	082508	092508			
4	12	TD	082508	092508			

MANUAL DRAFT | NUMBER | BD | DRAFT DATE | DRAFT TOTAL 2500

SPECIAL MESSAGE

PLIC 0354

PENNSYLVANIA LIFE INSURANCE CO.

October 8, 2008

Mike Russell

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

Dear Mr. Russell:

To assist in our evaluation of your claim, further information is required. Please provide our office with the following information at your earliest convenience.

- Sign and date the enclosed authorization.

A self-addressed envelope is enclosed for your use.

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

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 0356

AA-0403

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

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

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 Policy No: [redacted]9360
	Cell ~~Work~~	803-513-0575		

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 Highland 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 0359

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 (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? ~~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:

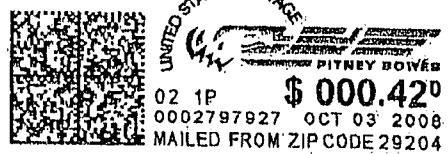
ADDRESS: 3 Medical Pk. Dr. Ste. 330 TELEPHONE 803-434-6958
Columbia, SC 29203

C-3 R Rev. 3-96

PLIC 0360

ROA 2103

Russell



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

32591+2355

PLIC 0361

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 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 0362

A & H CLAIM WORKSHEET

PAYEE NAME & ADDRESS - IF OTHER THAN AS SHOWN AT RIGHT

Mike Russell

DATE: 9/10/08

Rus

CLAIM NUMBER: 0809-00062

COMPLETE ONLY IF CLAIM IS FOR DEPENDENT
FIRST NAME: SPOUSE ☐ CHILD ☐

TAXPAYER I.D. NUMBER

L	REVIEW DATE	PAY TYPE
	09/11/08	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]9360	0120	8090	5088		✓							D

R#	BENEFIT	PLAN PROVIDER	FROM	TO	CHARGES	AMOUNT	O/R
1	50	Surgery (1904)	062408	062408	225/$200	150.00	O/R/V
2	12	TD (1901)	062508	062508	2,000		
4	12	TD (1901)	062508	062508	500		
5	50	Surgery (1904)	062408	062408	225/$200	180.00	O/R/V
6	53	Cast/Crunch (1946)	061808	061808	25		
6	60	Ambulance "	061808	061808	50		
6	61	X-Rays "	061808	061808	25		
6	62	1st Aid "	061808	061808	50		

MANUAL DRAFT NUMBER BD | DRAFT DATE | DRAFT TOTAL

SPECIAL MESSAGE: 7-Day Elimination Period applied

PLIC 0363

PHONE CALL REPORT

ADVISOR NAME: Ella Lee	DATE AND TIME: September 10, 2008 3:00 pm
Policy Number and Policy Form: [redacted]9360	
Claimant Name: Mike Russell	
Caller Name: Advisor	
Telephone Number: 803-513-0575	**Incoming?** **Outgoing? X**
Alternate Telephone Number: 803-955-0329	**Claim Number: 0809-00062**

NATURE OF CALL

Called insured to introduce myself as his claim advisor. I ask him how he was doing. He said as well as to be expected. He had a motorcycle accident on 06/18/08 at 9:20 pm. The doctor signed the PCF form for hospital stay as 06/20/08..He said he was in Lexington hospital (admitted early morning on 06/19/08) but they were not equipped to handle the surgery so they sent him to Richland to have it done on 06/20/08. He had surgery on his hip in which they put in a medal plate and his leg in which they put in a medal rod. He is currently on crutches and uses a walking boot. He could not remember if he was in icu. I informed him according to the hospital bill, it was not. He did go by ambulance to the hospital. He is expected to be out of work at least three months. The doctor said he can use about 20% of his body weight each month. No other surgeries are scheduled. He owns his company. I asked did he work or just supervise on the job. He said he is an on site worker. He also said he hopes that this does not take a long time. I informed him that I would be processing the claim today.

Follow up Required?	F/U Date:	2nd F/U Date:
3rd F/U Date:		

ADDITIONAL NOTES

Signature: Ella Lee	Date: 09/10/08

PLIC 0364

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

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	182.70
450 EMERGENCY ROOM GENERAL	3163.00
636 DRUG SPEC ID DETAIL CODING	34.00
710 RECOVERY ROOM GENERAL	1071.00
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

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

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) 835-0976, 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:	06/25/08
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

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	$

651711

0101

MICHAEL C RUSSELL
[redacted]

LEXINGTON MEDICAL CENTER
PO BOX 100273
COLUMBIA, SC 29202-3273

10237-P555 *TF90HAG5T000142

PLIC 0366

PALMETTO HEALTH RICHLAND
293 Greystone Blvd
First Floor
Columbia, SC 29210

A

☐ AMERICAN EXPRESS	☐ DISCOVER	☐	☐ VISA
CARD NUMBER			EXP. DATE
FULL NAME (Please Print)			CCV CODE
SIGNATURE			
PATIENT NAME AND ACCOUNT NUMBER			DATES OF SERVICE
MICHAEL C RUSSELL - 2081/200268			06/20/2008 - 07/01/200
ACCOUNT BALANCE	TOTAL CHARGES	AMOUNT PAID	
$77,387.21	$77,387.21	$	

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*

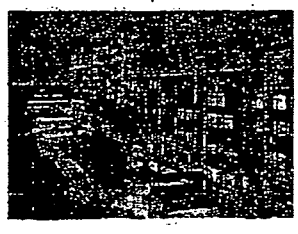
Contact us if any of this information is incorrect. Please note only primary and secondary insurances are listed on this statement.

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

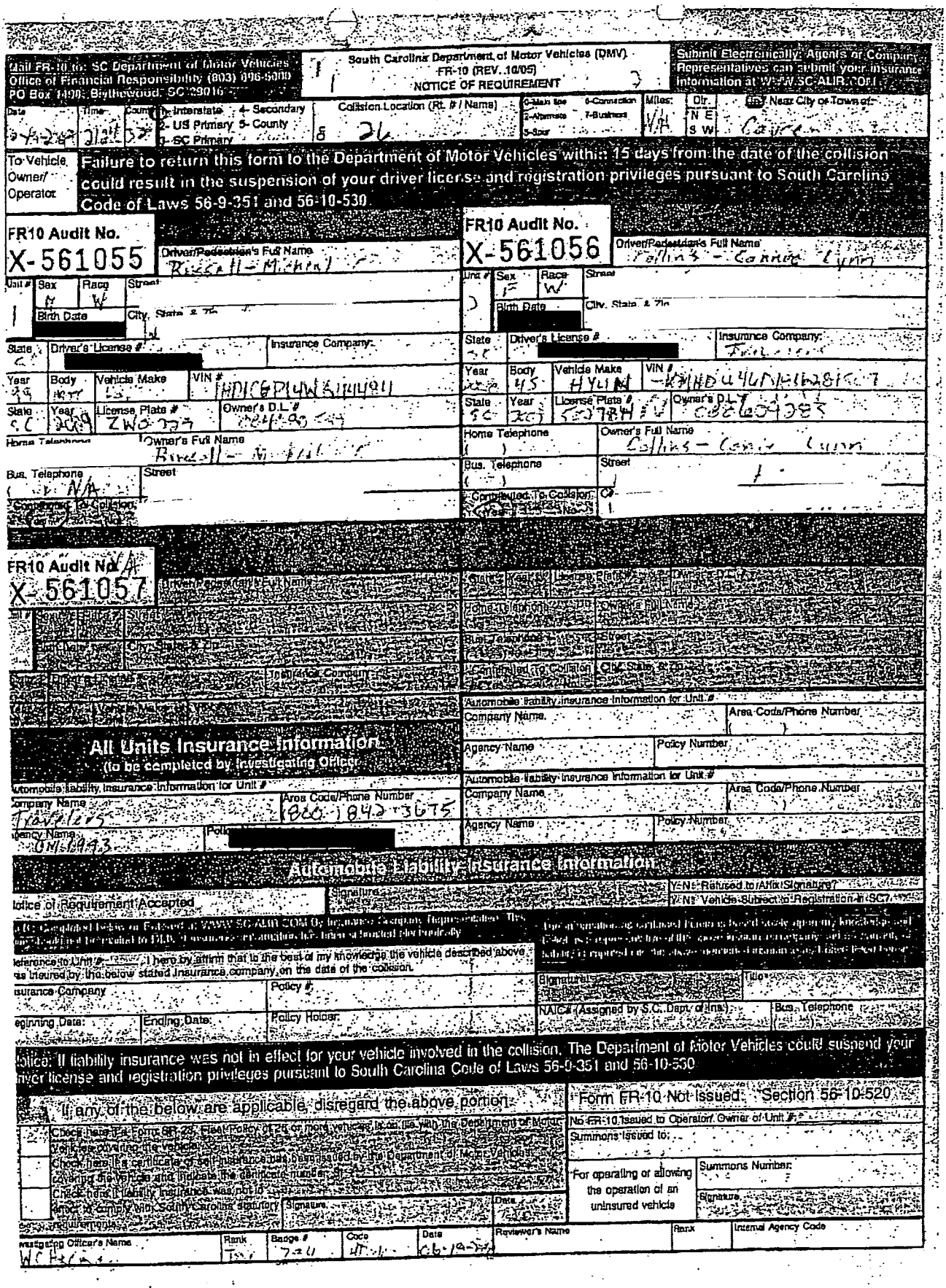
If you have any questions regarding this balance or would like an itemized statement, please contact our Patient Financial Services at 803-296-5098 or 800-243-7711. Monday through Friday, 8:30 a.m. to 5:00 p.m.. You may email questions to us at: www.palmettohealth.org. Written correspondence - Palmetto 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: 9-4-22 | Time: 2141 | County: 32 | 1- Interstate 4- Secondary 2- US Primary 5- County 3- SC Primary | Collision Location (Rt. # / Name): 8 26 | 0-Main Ipe 6-Connection 2-Alternate 7-Business 5-Bar | Miles: 1/4 | Dir.: N E S W | Near City or Town of: 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:

Birth Date: [redacted] | City, State & Zip:

State: SC | Driver's License #: [redacted] | Insurance Company:

Year: 20 | Body: HATC | Vehicle Make: Ca | VIN #: 1HDIC6P14WK314491

State: SC | Year: 2022 | License Plate #: ZWO 739 | Owner's D.L. #: [redacted]

Home Telephone: | Owner's Full Name: Russell - Michael

Bus. Telephone: ( ) N/A | Street:

Complained To Collision: Yes

FR10 Audit No. X-561056

Driver/Pedestrian's Full Name: Collins - Connie Lynn

Unit #: 2 | Sex: F | Race: W | Street:

Birth Date: [redacted] | City, State & Zip:

State: SC | Driver's License #: [redacted] | Insurance Company: Travelers

Year: 2022 | Body: 4S | Vehicle Make: HYUN | VIN #: KMHD84LF1NU281617

State: SC | Year: 2022 | License Plate #: SCJ784 | Owner's D.L. #: [redacted]

Home Telephone: | Owner's Full Name: Collins - Connie Lynn

Bus. Telephone: ( ) | Street:

Complained To Collision: Yes | City, State & Zip:

FR10 Audit No. X-561057

Driver/Pedestrian's Full Name:

Unit #: | Sex: | Race: | Street:

Birth Date: | City, State & Zip:

State: | Year: | License Plate #: | Owner's D.L. #:

Home Telephone: | Owner's Full Name:

Bus. Telephone: ( ) | Street:

Complained To Collision: | 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: 800 842 3675

Agency Name: ONSDA93 | Policy [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

Notice of Requirement Accepted | Signature: | Y-N: Refused to Affix Signature? | Y-N: Vehicle Subject to Registration in SC?

Reference to Unit #: I 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: | 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, Final Policy of 25 or more vehicles is on file with the Department of Motor Vehicles verifying 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 number
- Check here if liability insurance was not in effect or fails to comply with South Carolina statutory requirements

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:

Signature: | Date:

Investigating Officer's Name: W C Fisher | Rank: Trp | Badge #: 720 | Code: 4T | Date: 6-19-22

Reviewer's Name: | Rank: | Internal Agency Code:

PLIC 0369

0809-00062

PENNSYLVANIA LIFE INSURANCE COMPANY
Policyholder's Claim Report

Policy No. [redacted]9360 2 MIKE RUSSELL

IMPORTANT 8090

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: 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. Taglienti 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 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, it's 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 of 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.

Michael Russell 8-27-08

SIGNATURE OF INSURED/LEGAL REPRESENTATIVE DATE 1052C

PLIC 0370

ROA 2112

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 # 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 TRK 0215 8626 5812 4712

XH PNSA

811

00

FedEx. US Airbill

Express

FedEx Tracking Number 8626 5812 4

1 From This portion can be removed for Recipient's records.

Date 9/3/08 FedEx Tracking Number 8626581247 12

Sender's Name NIKE BARB Suzanne Tucci11 Phone 803 252-0606

Company BARB, SNYDER & CO

Address 1751 SAINT JULIAN PL Dept/Floor/Suite/Room

City COLUMBIA State SC ZIP 29204-2409

RECIPIENT: PEEL HERE

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

We cannot deliver to P.O. boxes or P.O. ZIP codes.

Address

To request a package be held at a specific FedEx location, print FedEx address here.

City Pensacola State FL ZIP 32501

0365132440

8626 5812 4712

fedex.com 1.800.GoFedEx 1.800.463.3339

Ergt 91360 03SEP08 USCA

up to 150 lbs.

FedEx First Overnight
Earliest next business morning delivery to select locations.* Saturday Delivery NOT available.

FedEx Priority Overnight
Next business afternoon delivery.* Saturday Delivery NOT available.

FedEx Standard Overnight
Next business afternoon delivery.* Saturday Delivery available.

* To most locations.

FedEx 2Day Freight
Second business day.** Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.

FedEx 3Day Freight
Third business day.** Saturday Delivery NOT available.

** To most locations.

Packages over 150 lbs.

5 Packaging

☒ FedEx Envelope* ☐ FedEx Pak* Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak ☐ FedEx Box ☐ FedEx Tube ☐ Other

* Declared value limit $500.

6 Special Handling

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

Includes FedEx address in Section 3.

Does this shipment contain dangerous goods?
One box must be checked.

☒ 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.

☒ Sender Acct. No. in Section 1 will be billed. ☐ Recipient ☐ Third Party ☐ Credit Card ☐ Cash/Check

Obtain Recipt. Acct. No.

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.

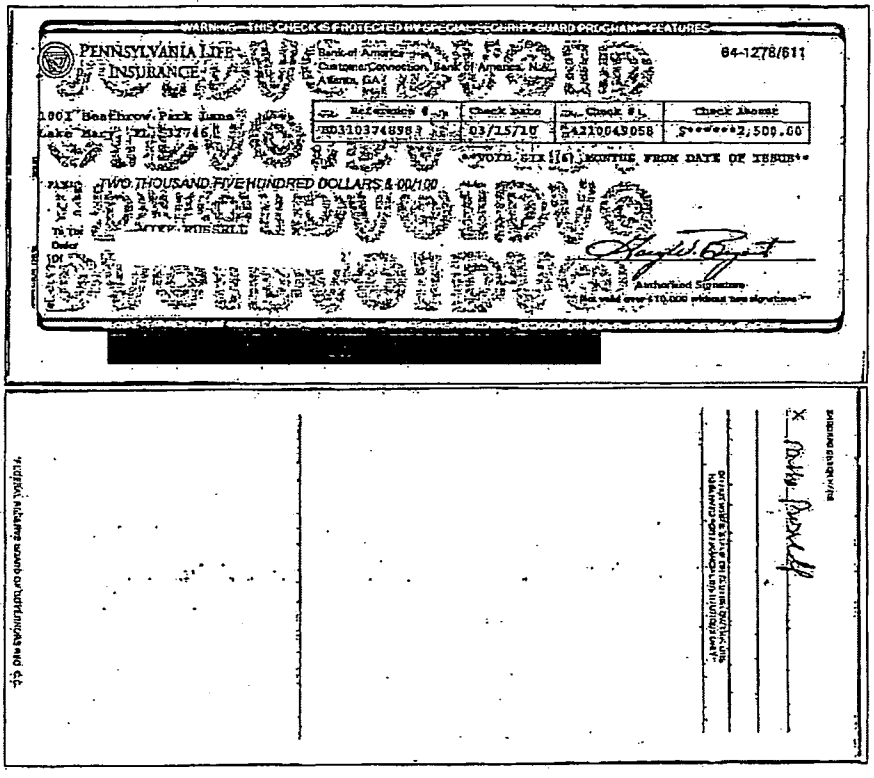
Indirect Signature
If no one is available at recipient's address, someone at a neighboring address may sign for delivery. Fee applies.

519

Rev. Date 10/08 • Part #150276-0121 • ©1994-2008 FedEx • PRINTED IN U.S.A. • SRS

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 0373

ROA 2115

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
DEPENDENT-

POLICY NO. [redacted]9360 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 0374

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 01-12-10
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

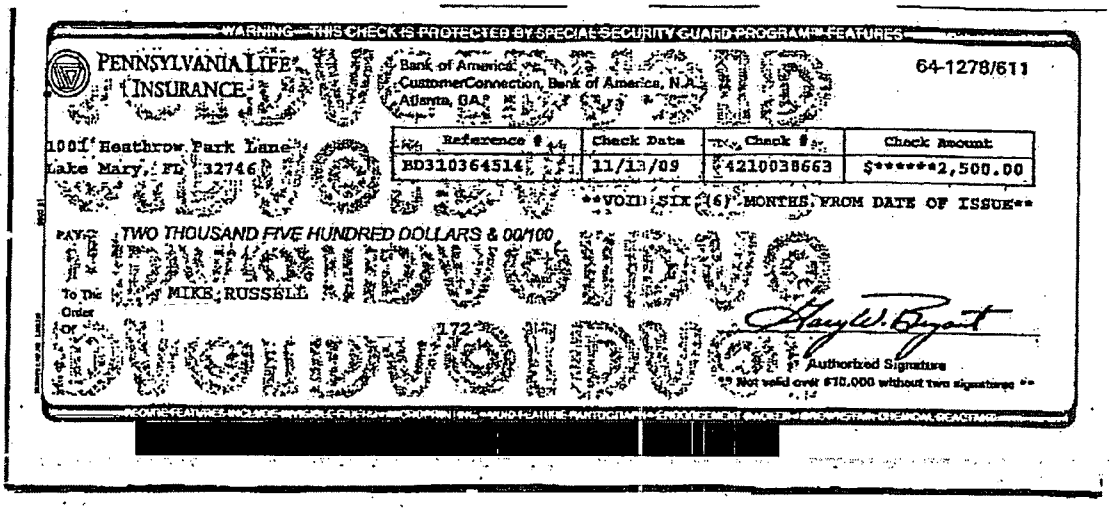
PARTIAL PAYMENT

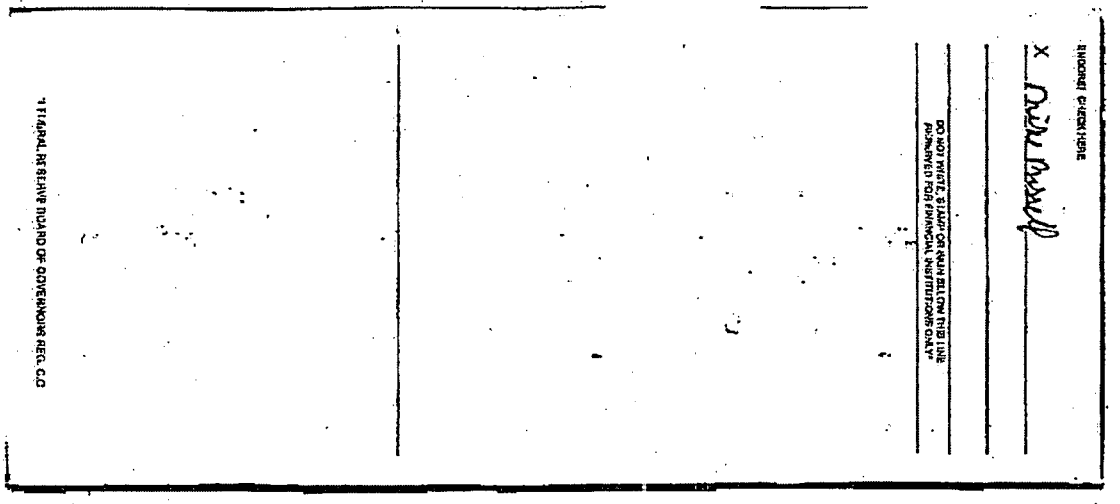
ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0375

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		

PLIC 0376

ROA 2118

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
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 0377

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

2

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 0378

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
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 0379

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 05-20-09
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 0380

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]3360 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 0381

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

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 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	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 0382

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 02-11-09
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 0383

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
ake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

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 0384

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

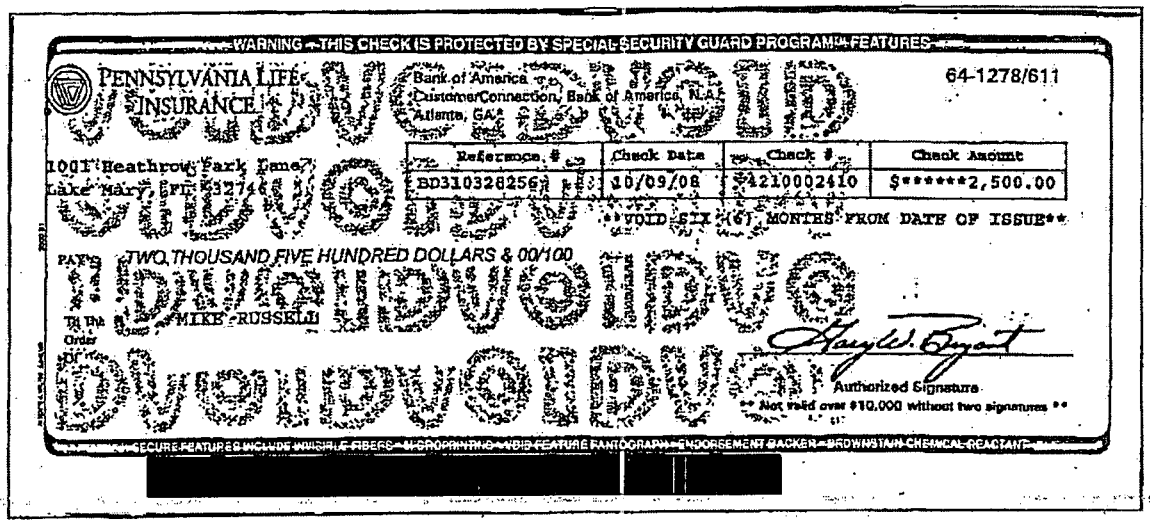
INSURED- MIKE RUSSELL — POLICY NO. [redacted]9360 — DATE PAID 11-14-08
DEPENDENT- — CLAIM NO. 0809-00062 — REF ID. BD310331298

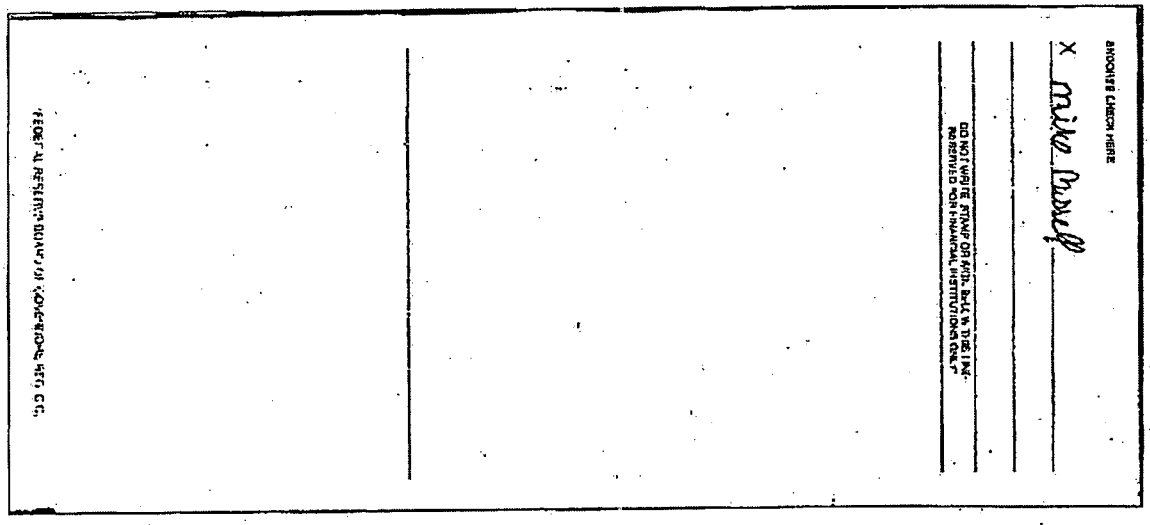
RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70 TOTAL DISABILITY	09-25-08	10-25-08	1MO	2000M	2,000.00
	TOTAL DISABILITY	09-25-08	10-25-08	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	13,125.00

PARTIAL PAYMENT

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

PLIC 0385





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	

PENNSYLVANIA LIFE INSURANCE COMPANY
ORLANDO, FLORIDA

06-278
611

BANK OF AMERICA

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

sC

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 0387

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
BD310374898	03/15/10	4210049058	$******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 4210049058
CHECK DATE 03/15/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 03-15-10
DEPENDENT- CLAIM NO. C809-00062 REF ID. BD310374898

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-10	02-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-10	02-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		53,125.00

PARTIAL PAYMENT

ADJ 8090 STATE 38 S/C C044413 M/C 091477

PLIC 0388

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
BD310385246	07/20/10	4210059426	$******7,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVEN 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 4210059426
CHECK DATE 07/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-20-10
CLAIM NO. 0809-00062 REF ID. BD310385246

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-10	05-25-10	3MO	2000M	6,000.00
	TOTAL DISABILITY	02-25-10	05-25-10	3MO	500M	1,500.00
				TOTAL THIS PAYMENT		7,500.00
				TOTAL PAID TO DATE		60,625.00

PARTIAL PAYMENT

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

PLIC 0389

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
BD310387907	08/26/10	4210062075	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

2

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210062075
CHECK DATE 08/26/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 08-26-10
CLAIM NO. 0809-00062 REF ID. BD310387907

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	05-25-10	07-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-10	07-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	65,625.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 B/C 0044413 M/C 091477

PLIC 0390

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

8050

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	803-955-0389	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 148 West Columbia SC 29169

3. On what dates were you treated since completing your last report?
   Dr. Odom - 3-15-10
   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?

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.

MAIL CENTER
APR 12 2010
PENSACOLA

DATE: 4-5-10 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0301

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 CENT

JUN 2 2 2010

PENSACO

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 997 Irmo, SC 29063

   Dr. Stone + Dr. Redmond - Lexington Co 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?

   5-17-10

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 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: 6-17-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

PLIC-0202

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

64-1278/611

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

Reference #	Check Date	Check #	Check Amount
BD310385246	07/20/10	4210059426	$******7,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVEN 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

CHECK NUMBER 4210059426
CHECK DATE 07/20/10

MIKE RUSSELL
SOURCE CODE ACL

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-20-10
CLAIM NO. 0809-00062 REF ID. BD310385246

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-10	05-25-10	3MO	2000M	6,000.00
	TOTAL DISABILITY	02-25-10	05-25-10	3MO	500M	1,500.00
					TOTAL THIS PAYMENT	7,500.00
					TOTAL PAID TO DATE	60,625.00

PARTIAL PAYMENT

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

PLIC 0303

PENNS LVANIA 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 23 2010

PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	Cell	803-513-0575		Policy No [redacted]9360
~~Work~~				

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 D. Hospital Dr. Suite 140
West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
7-19-10

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: 8-19-10 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0304

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
ke Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310387907	08/26/10	4210062075	$******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 4210062075
CHECK DATE 08/26/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 08-26-10
CLAIM NO. 0809-00062 REF ID. BD310387907

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901	70 TOTAL DISABILITY	05-25-10	07-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-10	07-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	65,625.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0205

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
BD310390322	09/23/10	4210064481	$******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 4210064481
CHECK DATE 09/23/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 09-23-10
CLAIM NO. 0809-00062 REF ID. BD310390322

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	07-25-10	08-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	07-25-10	08-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		68,125.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PENN. LVANIA LIFE INSURANCE CO. ANY

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 2 8 2010

PENSACOLA

MIKE RUSSELL

2

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0339	Age: 38	Claim No: 02-001-001-080900062
	Cell			Policy No [redacted]360
	~~Work~~	803-513-0525		

1. Describe the conditions causing your disability.
   motorcycle accident - broken hip + leg

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 O. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
   7-19-10

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.)
   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: 9-22-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev. 4-97

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
BD310392593	10/18/10	4210066744	$******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 4210066744
CHECK DATE 10/18/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 10-18-10
CLAIM NO. 0809-00062 REF ID. BD310392593

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	08-25-10	10-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	08-25-10	10-25-10	2MO	500M	1,000.00
					TOTAL THIS PAYMENT	5,000.00
					TOTAL PAID TO DATE	73,125.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PENN[illegible]LVANIA LIFE INSURANCE CO[illegible]ANY 8077

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

172

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	Cell ~~Work~~	803-513-0575		Policy No [redacted]93GC

1. Describe the conditions causing your disability.
motorcycle accident - broken hip + leg

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 10. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing your last report?
Dr. Odom - 9-30-10 Dr. Suarez 10-6-10

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.

MAIL CENTER
NOV 0 8 2010
PENSACOLA

DATE: 11-2-10 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0299

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
BD310395224	11/22/10	4210069375	$******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 4210069375
CHECK DATE 11/22/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 11-22-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310395224

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	10-25-10	11-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	10-25-10	11-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		75,625.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0400

8007

PENN 'LVANIA LIFE INSURANCE CO 'ANY

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: 38	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 hip + leg
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 D. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?	11-17-10
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, walking TV, completing exercises, reading, etc.

MAIL CENTER
DEC 13 2010
PENSACOLA

DATE: 12-8-10 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev 4-97

PLIC 0401

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
BD310397566	12/20/10	4210071712	$******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 4210071712
CHECK DATE 12/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 12-20-10
CLAIM NO. 0809-00062 REF ID. BD310397566

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	11-25-10	12-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	11-25-10	12-25-10	1MO	500M	500.00
					TOTAL THIS PAYMENT	2,500.00
					TOTAL PAID TO DATE	78,125.00

PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0402

PENNSY ANIA LIFE INSURANCE COMP IY

P. O. Box 12355, Pensacola, FL 32591-2355

17773

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 18 2011
PENSACOLA

MIKE RUSSELL

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0309	Age: 38	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 hip + leg

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?
mid-December - go back 1-10-11

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.)
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: 1-13-11 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev. 4-97

P8250028002

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

[redacted]

201101260143

Forwarding Service Requested

3-DIGIT 290
8670 0.7130 AT 0.354
MIKE RUSSELL 58
51

ENV 8670 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 01/26/2011
Check #: 8810702344
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted] Provider: Patient Acct #: Policy No: [redacted]9360						
12/25/10 - 01/24/11 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
12/25/10 - 01/24/11 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810702344
CHECK DATE: 01/26/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PENN 'LVANIA LIFE INSURANCE CO 'ANY

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

72

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	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? 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?
1-19-11

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: 2-17-11 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0405

PK25002B002

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

20110302O130

Forwarding Service Requested

3-DIGIT 290
777 0.7130 AT 0.354
MIKE RUSSELL 7

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 777 1 OF 3 F

Check Enclosed: Yes
Check Date: 03/02/2011
Check #: 8810713313
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	Patient Name: MIKE RUSSELL			Date of Birth: [redacted]		
Provider:	Patient Acct #:			Policy No: [redacted]9360		
01/25/11 - 02/24/11 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
01/25/11 - 02/24/11 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810713313
CHECK DATE: 03/02/2011

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

Void If not Cashed Within 90 Days

VOID

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

50 of 76

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.

17773

MIKE RUSSELL

2

Dependent Name:

CLAIMANT'S REPORT

Telephone Number-CELL	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900062
	~~Work~~	803-513-0515		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?
1-19-11 - Next 3-23-11

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.

MAIL CENTER
MAR 29 2011
PENSACOLA

DATE: 3-23-11 SIGNED: Mike Russell

ADDRESS: _____

C-3 R

Rev. 4-97

PR2500280002

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

20110309012 2

Forwarding Service Requested

MIXED AADC 290
22770 0.7130 MB 0.379
MIKE RUSSELL 428

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 22770 1 OF 3 F

Check Enclosed: Yes
Check Date: 03/09/2011
Check #: 8810714771
Check Amount: 333.33

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted] Provider: Patient Acct #: Policy No: [redacted]9360						
02/25/11 - 02/28/11 -- TOTAL DISABILITY BENEFITS	333.33	333.33	0.00	0.00	333.33	471
Claim Totals:	333.33	333.33	0.00	0.00	333.33	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810714771
CHECK DATE: 03/09/2011

AMOUNT
*****$333.33

PAY Three Hundred Thirty Three & 33/100 Dollars

Void if not Cashed Within 90 Days

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0408

PB2 S0015002

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

20110401013S

Forwarding Service Requested

3-DIGIT 290
1150 0.7130 AT 0.354

4

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 1150 1 OF 3 F

Check Enclosed: Yes
Check Date: 04/01/2011
Check #: 8810720061
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062	Patient Name: MIKE RUSSELL			Date of Birth: [redacted]		
Provider	Patient Acct #:			Policy No: [redacted]9360		
03/01/11 - 03/31/11 --	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit payment based upon the information that we have received. This payment is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's coverage determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810720061
CHECK DATE: 04/01/2011

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0409

PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

PENNSYLVANIA LIFE INSURANCE

Forwarding Service Requested

3-DIGIT 290
3381 0.7130 AT 0.362
MIKE RUSSELL 14

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 3381 1 OF 3 F

Check Enclosed: Yes
Check Date: 04/29/2011
Check #: 8810728796
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 0080900062 Patient Name: MIKE RUSSELL Date of Birth: [redacted] Provider: Patient Acct #: Policy No: [redacted]9360						
04/01/11 - 04/30/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

PENNSYLVANIA LIFE INSURANCE
PENNSYLVANIA LIFE INSURANCE CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810728796
CHECK DATE: 04/29/2011

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

Void if not Cashed Within 90 Days

VOID

FST C 2

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

80%

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.

17773

MAIL CENTER

MAY 02 2011

PENSACOLA

MIKE RUSSELL

S[redacted]2

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	803-955-0329	Age: 38	Claim No: 02-001-001-080900052
	~~Work~~ Cell	803-513-0575		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg + hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Odom PO Box 1997 Elgin, SC 29063
   Dr. Suarez + Dr. Dedmond - Lexington 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169 — Orthopedics

3. On what dates were you treated since completing your last report?
   3-23-11

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, walking to, completing exercises, reading, etc.

DATE: 4-28-11 SIGNED: Mike Russell

ADDRESS:

C-3 R

Rev. 4-97

PLIC 0429

ROA 2153

PENNSYLVANIA LIFE INSURANCE COMPANY

P. O. Box 12355, Pensacola, FL 32591-2355

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code:	See previous
2. Describe any other conditions contributing to present disability.	See previous
3. Describe dates of treatment since last report and indicate if patient is still under your care	Dates of treatment since last report:
3a. Next Appointment Date:	Patient discharged on: 3/23/11
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?	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: 4-26-11 SIGNED: Landon S Mabry, MD

ADDRESS: Lexington Orthopaedics 146 N. Hospital Drive, Ste. 140 West Columbia, SC 29169 (803) [redacted]-7230 TELEPHONE

C-3 R

Rev. 3-96

PLIC 0430

ROA 2154

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

8076

ENV 3381 2 OF 3 F

Mike Russell

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home	Age:	Claim No: 02-001-001-08090006a
cell	~~Work~~	38	Policy No: [redacted] 9360

1. Describe the conditions causing your disability.	motorcycle accident - broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you? Dr. Motto-3 mides pain mgmt. 109 Midlands Ct, West Columbia, SC 29169	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 our last report?	4-21-11) 5-6-11
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: 5-20-11 SIGNATURE Mike Russell

ADDRESS: [redacted]

C-3 R Rev 11/10

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 3381 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	Sane
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: NA
3a. Next Appointment Date: NA	Patient discharged on: 3-23-11
4. Has the patient been confined to a hospital since completing your last report? NA (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?	NA
6. When did or will your patient be able to resume full work?	NA
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 IS 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: 5-25-11 SIGNATURE Randall S. Sharp, MD

ADDRESS TELEPHONE

C-3 R Rev 11/10

Page 2 of 4

MAIL CENTER
JUN 02 2011
PENSACOLA

PLIC 0432

ROA 2156

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

8076

ENV 2227 2 OF 3 P

Mike Russell

Dependent Name:

CLAIMANT'S REPORT

Telephone Number			Age:	Claim No: 02-001-001-0809000062
Home	803-955-0329			
Cell	Work 803-513-0575		38	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg + hip pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Motto - 3 Rivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169
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 our last report?
5-6-11, 7-1-11

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 [illegible]
Address
Admitted: JUL 11 2011
Discharged: PENSACOLA

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: 7-1-11 SIGNATURE Mike Russell

ADDRESS:

C-3 R Rev 1/10

PAID 7/25/11 QP

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2227 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
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. Patient remains under my care and is seen Q4-8 weeks	Dates of treatment since last report: 4/21/11, 5/6/11, 7/1/11
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). N/A	Hospital: N/A 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? NO 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 IS 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: 7/1/11 SIGNATURE

ADDRESS 169 A Medical Circle, W. Columbia, SC 29169 TELEPHONE 803-454-1661

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 777 2 OF 3 F

Mike Russell

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home ~~Work~~ Cell Age: 39	Claim No: 02-001-001-080900062 Policy No: [redacted]9360
1. Describe the conditions causing your disability.	motorcycle accident - broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you? Dr. McHo-Shivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169	Dr. Storez & Dr. Redmond - Lexington Orthopedics 1416 D. Hospitol Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing our last report?	7-1-11
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: 8-3-11 SIGNATURE Mike Russell

ADDRESS: [redacted]

C-3 R Rev 11/10

PLIC 0435

PH150028U07

80%

PENNSYLVANIA LIFE INSURANCE

PENNSYLVANIA LIFE INSURANCE COMPANY
Executive Offices: P.O. 12365, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

PENSACOLA
AUG 08 2011
MAIL CENTER

ENV 777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt. is seen Q 4-8 weeks for the management of his pain medications	Dates of treatment since last report: 4/21, 5/6, 7/1
3a. Next Appointment Date: 8/26/11	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). N/A	Hospital: N/A 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? N/A 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 IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Questions of disability +/or fitness to work lie outside the scope of this practice and will not be addressed. If not already done, I would recommend that this patient be referred for a Functional Capacity Evaluation, followed by an Independent Medical Evaluation by a Rehabilitation Medicine Specialist, within whose expertise these questions more appropriately lie.

Ind. Practitioner's Soc. Sec. #
[redacted]

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 7/29/11 SIGNATURE _____

ADDRESS 169 A Medical Circle TELEPHONE 803-454-1661

West Columbia, S.C. 29169

8/22

C-3 R Rev 11/10

PAID

PLIC 0436

RMO5477711

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7368

2 OF 3 F

ENV 39752

PAID 092811 JP

IMAGING

SEP 01 2011

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home / ~~Work~~ / Cell	Age:	Claim No: 02-001-001-080900062
		39	Policy No: [redacted]3600

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip + pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Soltz + Dr. Dedmond - Lexington Orthopedics
Dr. MoHQ - 3 Rivers Pain Mgmt. 146 N. Hospital Dr. Suite 140
109 Midlands Ct. West Columbia, SC 29169 West Columbia SC 29169

3. On what dates were you treated since completing our last report?
7-1-11, 8-26-11

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, walking to, completing exercises, reading, etc.

DATE: 8-26-11 SIGNATURE [signature]

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0437

RMO5477711

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 39752 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 Pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q 4-8 weeks for the management of his medications	Dates of treatment since last report: 4/21, 5/6, 7/1, 8/26
3a. Next Appointment Date:	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). N/A	Hospital: N/A 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? no 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 IS FOR ANY ADDITIONAL COMMENT YOU MAY CARE TO MAKE CONCERNING PATIENT'S CONDITION.

Questions of disability +/or fitness to work lie outside the scope of this practice and will not be addressed. If not already done, I would recommend that this patient be referred for a Functional Capacity Evaluation, followed by an Independent Medical Evaluation by a Rehabilitation Medicine Specialist, within whose expertise these questions more appropriately lie.

Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: 8/26/11 SIGNATURE

ADDRESS 169A Medical Circle W Columbia, S.C 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0438

RMO5525300

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 12777

Mike Russell

IMAGING

OCT 11 2011

Dependent Name:

CLAIMANT'S REPORT

Telephone Number: Cell / ~~Work~~ / Home		Age: 39.	Claim No: 03-001-001-0809000 62 Policy No: [redacted] 9360

1. Describe the conditions causing your disability. motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. MoHO - 3 Rivers Pain mgmt 109 Midlands Ct. West Columbia, SC 29169 — Dr. Suarez + Dr. Dedmon - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report? 8-26-11

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: 10-11 SIGNATURE Mike Russell

ADDRESS: _____

C3 R Rev 11/10

PLIC 0439

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12365, Pensacola, FL 32591-2365 Toll Free 1-800-275-7366

ENV 12777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: Pain in limb - 729.5	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen q 4-8 weeks for the mgmt of his ~~cept~~ medications.	Dates of treatment since last report: 4/21, 5/6, 7/1, 8/26, 9/9, 11/3
3a. Next Appointment Date: 11/3/11	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). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? NO 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 IS 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: 10/4/11 SIGNATURE

ADDRESS 1169 A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1664

C-3 R Rev 11/10

PLIC 0440

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 F

Mike Russell

IMAGING
DEC 27 2011

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Cell ~~Home~~ ~~Work~~ [redacted] Age: 39	Claim No: 02-001-001-08090006a Policy No: [redacted]9360
1. Describe the conditions causing your disability. motorcycle accident - broken leg, hip, pelvic bone	
2. What is the name and address of all physicians currently treating you? Dr. Mollo-3 Rivers Pain Mgmt 109 Midlands Ct. West Columbia, SC 29169	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 our last report?	12-2-11
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:

DATE: 12-21-11 SIGNATURE Mike Russell

ADDRESS: [redacted]

C-3 R Rev 11/10

PLIC 0441

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: Pain in limb - 729.5	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt. is seen Q4-8 weeks for the mgmt. of his medications	Dates of treatment since last report: 4/1, 5/6, 7/1, 8/26, 9/9, 11/13,
3a. Next Appointment Date:	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). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? no 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 IS 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: 12/21/11 SIGNATURE

ADDRESS 169 A Medical Circle TELEPHONE 803-454-1616

W. Columbia, S.C. 29169

C-3 R Rev 11/10 Page 2 of 4

PLIC 0442

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

MAIL CENTER
JAN 30 2012
PENSACOLA

ENV 959 2 OF 3 F

Mike Russell

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home [redacted]9	Age: 39	Claim No: 03-001-001-080900062 Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. moHo - 3 rivers Pain mgmt. 107 midlands Ct. West Columbia, SC 29169
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 our last report?
12-2-11

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:
Reading, watching TV, Completing ~~exercises~~ exercises, etc.

DATE: 1-25-12 SIGNATURE Mike Russell

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0443

RMO5673393

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2356 Toll Free 1-800-275-7366

ENV 959 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. 729.5- ICD CODE: Pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. patient seen Q4-8 weeks for the mgmt of his medications	Dates of treatment since last report: 4/1, 5/6, 7/1, 8/26, 9/9, 11/3, 12/2
3a. Next Appointment Date: 1/27/12	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). N/A	Hospital: Address Admitted: Discharged:
5. When did or will your patient be able to resume some work or activity? N/A	
6. When did or will your patient be able to resume full work? N/A	
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 IS 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: 1/24/12 SIGNATURE

ADDRESS 1169 A Medical Circle W. Columbia S.C. 29169 TELEPHONE 803-454-1161

C-3 R Rev 11/10

PLIC 0444

DCL5719130

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 2012
PENSACOLA

MIKE RUSSELL
1

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ Cell	Age: 39
Claim No: 02-001-001-080900062	Policy No: [redacted]9360

1. Describe the conditions causing your disability.
   motorcycle accident - broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you? Dr. Moho - 3 mos pain mgmt 109 Midlands Ct. West Columbia, SC 29169
   Dr. Suarez + Dr. Dodmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing your last report?
   1-27-12
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:

reading, watching TV, completing exercises etc.

DATE: 2-28-12 SIGNED: Mike Russell

ADDRESS:

C-3 R Rev. 4-97

PLIC 0445

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

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD Code: 729.5-pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care Yes- medication mgmt 3a Next Appointment Date: 3/14/12	Dates of treatment since last report: 1/11, 5/6/11, 7/1/11, 8/26/11, 9/9/11, 11/5/11, 12/2/11, Patient discharged on: N/A 1/27/12
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? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. (See definition of CONFINEMENT below.) N/A	☐ 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: 2/22/12 SIGNED: [signature]

ADDRESS: 169A Medical Circle West Columbia, S.C. 29169 TELEPHONE (803)454-1661

C-3 R Rev. 3-96

DCL6719130

PLIC 0446

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2365 Toll Free 1-800-275-7366

Mike Russell

MAIL CENTER
APR 03 2012
PENSACOLA

ENV 6053 2 OF 3 F

Dependent Name:

CLAIMANT'S REPORT

Telephone Number: Home ~~Work~~ Cell; Age: 39	Claim No: 02-001-001-08090006 Policy No: [redacted]3.60
1. Describe the conditions causing your disability. motorcycle accident broken leg, hip, pelvic bone	
2. What is the name and address of all physicians currently treating you? Dr. Mono - Rivers Pain Mgmt 109 midlands Ct. West Columbia, SC 29169	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 our last report? 3-14-12	
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:

Reading, Watching TV, Completing exercises, etc.

DATE: 3-29-12 SIGNATURE Mike Russell

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0447

BKE5759192

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 6053 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. n/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8wk for med. mgmt.	Dates of treatment since last report: 3/14/12
3a. Next Appointment Date: 5/7/12	Patient discharged on: n/A
4. Has the patient been confined to a hospital since completing your last report? UNO (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? n/A	
6. When did or will your patient be able to resume full work? n/A	
7. As a result of this condition, was the patient confined to the house? UNO 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 IS 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: 3/29/12 SIGNATURE

ADDRESS 169 A Medical Circle TELEPHONE 803-454-11616

C-3 R Rev 11/10 West Columbia, S.C. 29169

PLIC 0448

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-276-7366

ENV 845 2 OF 3 F

mike Russell
hd.

Dependent Name:

CLAIMANT'S REPORT

Telephone Number Home / ~~Work~~ / Cell; Age: 39	Claim No: 08-001-001-080900068 Policy No: [redacted]93600
1. Describe the conditions causing your disability. motorcycle accident - broken leg, hip, pelvic bone	
2. What is the name and address of all physicians currently treating you? Dr. Moho - Rivers Pain Mgmt. 109 Midlands Ct. West Columbia, SC 29169	Dr. Sucrez Dr. Redmond - Lexington Orthopedics 146 N. Hospital Dr. Suite 148 West Columbia, SC 29169
3. On what dates were you treated since completing our last report?	3-14-12
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:

Reading, Watching TV, Completing exercises, etc.

MAIL CENTER
MAY 15 2012
PENSACOLA

DATE: 5-8-12 SIGNATURE Mike Russell

ADDRESS: _____

C-3 R Rev 11/10

BKE5815986

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8 weeks for med. mgmt	Dates of treatment since last report: 5/7/12
3a. Next Appointment Date:	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? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? NO 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 IS 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: 5/7/12 SIGNATURE

ADDRESS 169 A Medical Circle West Columbia, SC 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0450

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 1248

Mike Russell

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number Cell / ~~Work~~	Age: 39	Claim No: 02-601-001-08090006 Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident - broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mohd - 3 Rivers Pain Mgmt, 109 Fortress Ct. West Columbia, SC 29169
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 our last report?
5-7-12

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.

MAIL CENTER
JUN 18 2012
PENSACOLA

USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:
Reading, watching TV, completing exercises, etc.

DATE: 6-12-12 SIGNATURE Mike Russell

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0451

PR150028000

20120329116

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 1248 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5- pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8w for med. mgmt.	Dates of treatment since last report: 5/7/12
3a. Next Appointment Date: 6/22/12	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? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? If "YES", show dates confined. no (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 IS 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: 6/12/12 SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, SC 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0452

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 17395 2 OF 3 F

mike russell

Dependent Name: MIKE RUSSELL

RECEIVED
JUL 20
By

CLAIMANT'S REPORT

Telephone Number: Home ____ Cell ~~Work~~ Age: 40	Claim No: 02-001-001-08090006Z Policy No: [redacted]9360
1. Describe the conditions causing your disability.	motorcycle accident- broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you?	Dr. Redmond + Dr. Suarez- Lexington-Ortho pedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169 Dr. Mohio-3 Rivers Pain Mgmt 109 Midlands Ct. West Columbia, SC 29169
3. On what dates were you treated since completing our last report?	6-22-12
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:

reading, watching TV, completing exercises, etc.

DATE: 7-16-12 SIGNATURE Mike Russell

ADDRESS: ____

C-3 R Rev 11/10

PLIC 0453

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 17395 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8 weeks for med mngmt	Dates of treatment since last report: 6/22/12
3a. Next Appointment Date: 8/14/12	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? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? no 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 IS 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: 7/16/12 SIGNATURE

ADDRESS 169A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0454

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

Mike Russell

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 863 2 OF 3 F

RECEIVED
AUG 27 2012
By

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number: Home / ~~Work~~ / Cell; Age: 40	Claim No: 02-001-001-08090006a Policy No: [redacted]9360
1. Describe the conditions causing your disability.	motorcycle accident- broken leg, hip, pelvic bone
2. What is the name and address of all physicians currently treating you?	Dr. Mohr 3 Rivers Pain Mgmt. 109 Midlands Ct. West Columbia SC 29169; Dr. Redmond + Dr. Suarez - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169
3. On what dates were you treated since completing our last report?	6-22-12, 8-14-12
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:

Reading, watching TV, completing exercises, etc.

DATE: 8-21-12 SIGNATURE Mike Russell

ADDRESS: _____

C-3 R Rev 11/10

UNION BANKERS INSURANCE COMPANY
On behalf of Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7368

ENV 863 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 pain in limb	
2. Describe any other conditions contributing to present disability. n/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt. is seen Q4-8 weeks for med mgmt	Dates of treatment since last report: 8/14/12
3a. Next Appointment Date: 10/9/12	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? n/A	
6. When did or will your patient be able to resume full work? n/A	
7. As a result of this condition, was the patient confined to the house? no 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 IS 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: 8/20/12 SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, S.C. 29123 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0456

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

Mike Russell

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

RECEIVED
OCT 01 2012
By

ENV 19181 2 OF 3 F

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number: Home ~~Work~~ Cell	Age: 40
Claim No: 03-001-001-08090006a Policy No: [redacted]9360	

1. Describe the conditions causing your disability. motorcycle accident - broken leg, hip + pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mollo - 3 Rivers Pain Management 109 Midlands Ct. West Columbia, SC 29169. Dr. Desmond + Score - Lexington Orthopedics 146 D. Hospital Dr. Suite 140 West Columbia, SC 29169.

3. On what dates were you treated since completing our last report? 8-14-12

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:

DATE: 9-25-12 SIGNATURE Mike Russell

ADDRESS: [redacted]

C-3 R Rev 11/10

PLIC 0457

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7368

ENV19181 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 Pain in limb 784.0 - Cephalgia	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. Pt is seen Q4-8 weeks for med. mgmt	Dates of treatment since last report: 8/14/12
3a. Next Appointment Date: 10/9/12	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? N/A	
6. When did or will your patient be able to resume full work? N/A	
7. As a result of this condition, was the patient confined to the house? NO 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 IS 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: 9/25/12 (C) SIGNATURE

ADDRESS 169 A Medical Circle W. Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10 Page 2 of 4

PLIC 0458

ROA 2182

P8350228ooC

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Mike Russell

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7368

ENV 13704 2 OF 3 F

Dependent Name: MIKE RUSSELL

NOV 05 2012

CLAIMANT'S REPORT

Telephone Number	Home [redacted]	Age: 40	Claim No: 03-001-001-080900062
Cell	Work [redacted]		Policy No: [redacted]9360

1. Describe the conditions causing your disability.
motorcycle accident- broken leg, hip, pelvic bone

2. What is the name and address of all physicians currently treating you? Dr. Mallo - 3 Rivers Pain Management Inc Midlands, Ste. West Columbia, SC 29169
Dr. Redmond & Dr. Suarez - Lexington Orthopedics 146 N. Hospital Dr. Suite 140 West Columbia, SC 29169

3. On what dates were you treated since completing our last report?
10-9-12

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:
reading, watching TV, completing exercises, etc.

DATE: 10-31-12 SIGNATURE Mike Russell

ADDRESS: [redacted]

C-3 R Rev 11/10

PLIC 0459

UNION BANKERS INSURANCE COMPANY

On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

FNV 11704 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE: 729.5 - pain in limb	
2. Describe any other conditions contributing to present disability. N/A	
3. Describe dates of treatment since last report and indicate if patient is still under your care. pt is seen Q4-8 weeks for med mgmt	Dates of treatment since last report: 10/9/12
3a. Next Appointment Date: 12/11/12	Patient discharged on: N/A
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? N/A	
6. When did or will your patient be able to resume full work? N/A	
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 IS 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: 10/30/12 SIGNATURE _____

ADDRESS 169 A Medical Circle West Columbia, S.C. 29169 TELEPHONE 803-454-1661

C-3 R Rev 11/10

PLIC 0460

P6250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
6053 0.7130 AT 0.371
MIKE RUSSELL 42

201203010133

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 6053 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 03/01/2012
Check #: 8810801176
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
02/01/12 - 02/29/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
02/01/12 - 02/29/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810801176
CHECK DATE: 03/01/2012

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0461

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

20120301013

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 6053 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

PN25002R002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
845 0.7130 AT 0.371
MIKE RUSSELL 11

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201203280115

ENV 845 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 03/28/2012
Check #: 8810806996
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
03/01/12 - 03/31/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810806996
CHECK DATE: 03/28/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0466

PS75002E307

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F
ENV 845

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PB250028007

20120728011S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 845 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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STATE REGULATORY FRAUD NOTICES

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P6250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

ALL FOR AADC 290
17395 0.7130 AB 0.371
MIKE RUSSELL 161

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

20120425011?

ENV 17395 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 04/25/2012
Check #: 8810813434
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
04/01/12 - 04/30/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810813434
CHECK DATE: 04/25/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

[redacted]

VOID

PLIC 0471

P825002800C

20120425011 7

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 17395

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No:
	Work			Policy No: [redacted]9360

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0472

ROA 2196

P625002300C

20120425017

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 17395 2 OF 3 R

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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THIS SPACE IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20130430117

STATE REGULATORY FRAUD NOTICES

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ENV 17395 3 OF 3 F

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
1248 0.7130 AT 0.371
MIKE RUSSELL 12

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201205230116

ENV 1248 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 05/23/2012
Check #: 8810819713
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
05/01/12 - 05/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
05/01/12 - 05/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

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UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810819713
CHECK DATE: 05/23/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF **MIKE RUSSELL**

VOID

[redacted]

PLIC 0476

P#25002500C

20120523201 16

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 1248

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

P8250028000

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 1248 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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THIS SPACE IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

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STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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PE250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2227 0.7130 AT 0.362
MIKE RUSSELL 10

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201105270131

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 2227 1 OF 3 F

Check Enclosed: Yes
Check Date: 05/27/2011
Check #: 8810736498
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible	Paid Amount	Remark Codes
Claim #: 00809000 2 Patient Name: MIKE RUSSELL Date of Birth: [redacted]						
Provider: Patient Acct #: Policy No: [redacted]9360						
05/01/11 - 05/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810736498
CHECK DATE: 05/27/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0481

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PB2500250D7

20110527013

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2227 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

[redacted]

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

P6250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
13704 0.7130 MB 0.401
MIKE RUSSELL 327
1469 DOGWOOD RD
WEST COLUMBIA, SC 29172-2451

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

20120711O120

ENV 13704 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 06/29/2012
Check #: 8810828330
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Provider:**	**Patient Name:** MIKE RUSSELL **Patient Acct #:**			**Date of Birth:** [redacted] **Policy No:** [redacted]9360		
06/01/12 - 06/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
06/01/12 - 06/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

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UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810828330
CHECK DATE: 06/29/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0486

ROA 2210

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20120711010

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

20130711013D

STATE REGULATORY FRAUD NOTICES

ENV 13704 3 OF 3 B

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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NOTICE IN ALL OTHER STATES: 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.

PE250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
863 0.7130 AT 0.371
MIKE RUSSELL 10

201207250121

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 863 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 07/25/2012
Check #: 8810833168
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
07/01/12 - 07/31/12 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

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UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810833168
CHECK DATE: 07/25/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF **MIKE RUSSELL**

VOID

[redacted]

PLIC 0491

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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: _____

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USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20120725012I

STATE REGULATORY FRAUD NOTICES

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NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

3 OF 3 F

ENV 863

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
39752 0.7130 MB 0.387
MIKE RUSSELL 299

201107270146

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

ENV 39752 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 07/27/2011
Check #: 8810751432
Check Amount: 5,000.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Provider:**	**Patient Name:** MIKE RUSSELL **Patient Acct #:**			**Date of Birth:** [redacted] **Policy No:** [redacted]9360		
06/01/11 - 06/30/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
07/01/11 - 07/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	5,000.00	5,000.00	0.00	0.00	5,000.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810751432
CHECK DATE: 07/27/2011

AMOUNT
*****$5,000.00

Void if not Cashed Within 90 Days

PAY Five Thousand Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0496

P8250022007

20110727014G

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 39752 2 OF 3 F

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

PE150028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
12777 0.7130 AT 0.362
MIKE RUSSELL 58

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

ENV 12777 1 OF 3 F

Check Enclosed: Yes
Check Date: 08/24/2011
Check #: 8810758384
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted] **Provider:** **Patient Acct #:** **Policy No:** [redacted]360						
08/01/11 - 08/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810758384
CHECK DATE: 08/24/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0501

P8250028007

20110824014S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 12777

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PE250028007

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 12777 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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THIS SPACE IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20110824014S

STATE REGULATORY FRAUD NOTICES

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NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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NOTICE IN ALL OTHER STATES: 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.

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
19181 0.7130 MB 0.401
MIKE RUSSELL
437

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

[redacted]

ENV 19181 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 08/29/2012
Check #: 8810840118
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Provider:**	**Patient Name:** MIKE RUSSELL **Patient Acct #:**			**Date of Birth:** [redacted] **Policy No:** [redacted]9360		
08/01/12 - 08/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
08/01/12 - 08/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810840118
CHECK DATE: 08/29/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

1469 DOGWOOD RD

WEST COLUMBIA, SC 29172

VOID

[redacted]

PLIC 0506

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STATE REGULATORY FRAUD NOTICES

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NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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NOTICE IN ALL OTHER STATES: 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.

PE250026002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

201210240116

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

3-DIGIT 290
917 0.7130 AT 0.371
MIKE RUSSELL 13

ENV 917 1 OF 3 F

Call 888-802-9497 to speak with us.

Check Enclosed: Yes
Check Date: 10/17/2012
Check #: 8810850706
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
09/01/12 - 09/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
09/01/12 - 09/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810850706
CHECK DATE: 10/17/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0511

PF25002800C

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 917 2 OF 3 F

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

C-3 R Rev 11/10

PLIC 0512

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

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STATE REGULATORY FRAUD NOTICES

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P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
12423 0.7130 AT 0.362
MIKE RUSSELL 53

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201110260135

ENV 12423 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 10/26/2011
Check #: 8810773923
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
10/01/11 - 10/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810773923
CHECK DATE: 10/26/2011

AMOUNT
*****$2,500.00

Void If not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0516

P[2500]28007

20111026013S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F

ENV 12423

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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: _____

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USE THIS SPACE TO DESCRIBE HOW YOU SPEND YOUR TIME:

DATE: _____ SIGNATURE _____

ADDRESS: _____

20111026155

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 12423 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

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NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

PS250026002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

MIXED AADC 290
13730 0.7130 MB 0.401
MIKE RUSSELL 358

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201211140114

[redacted]

ENV 13730 1 OF 3 F

Call 888-802-9497 to speak with us.

Check Enclosed: Yes
Check Date: 11/14/2012
Check #: 8810855783
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
10/01/12 - 10/31/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
10/01/12 - 10/31/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810855783
CHECK DATE: 11/14/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0521

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No: [redacted]9360
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

20121114014

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

ENV 13730 3 OF 3 F

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

PS250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2376 0.7130 AT 0.362
MIKE RUSSELL 9

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

201111230140

ENV 2376 1 OF 3 F.

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 11/23/2011
Check #: 8810780557
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
11/01/11 - 11/30/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810780557
CHECK DATE: 11/23/2011

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0526

PS250028007
20111130140

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F
ENV 2376

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

P8250028007

20111230140

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

ENV 2376 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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NOTICE IN NEW MEXICO, LOUISIANA, MARYLAND: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

STATE REGULATORY FRAUD NOTICES

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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NOTICE IN ALL OTHER STATES: 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.

PE250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
2865 0-7130 AT 0-371
MIKE RUSSELL
30

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

Call 888-802-9497 to speak with us.

ENV 2865 1 OF 3 F

Check Enclosed: Yes
Check Date: 11/30/2012
Check #: 8810859249
Check Amount: 2,500.00 Page 1 of 3

Explanation of Benefits - This is not a Bill

Service Dates – Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
11/01/12 - 11/30/12 -- TOTAL DISABILITY BENEFITS	2,000.00	2,000.00	0.00	0.00	2,000.00	471
11/01/12 - 11/30/12 -- TOTAL DISABILITY BENEFITS	500.00	500.00	0.00	0.00	500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:
471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE
We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810859249
CHECK DATE: 11/30/2012

AMOUNT
*****$2,500.00

Void if not Cashed Within 90 Days

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

VOID

[redacted]

PLIC 0531

P825002R00C

20121300116

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

2 OF 3 F

ENV 2865

Dependent Name: MIKE RUSSELL

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No:
	Work			Policy No: [redacted]9360

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PB250025DOC

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 13667, Pensacola, FL 32591-3667 Toll Free 1-800-275-7366

ENV 2865 2 OF 3 B

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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 IS 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: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

STATE REGULATORY FRAUD NOTICES

NOTICE IN ALASKA, ARKANSAS, VIRGINIA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

NOTICE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

NOTICE IN CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

NOTICE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE IN IDAHO, INDIANA: Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony.

NOTICE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE IN MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE IN NEW HAMPSHIRE: Any person who, with a purpose to injure defrauds or deceives any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NOTICE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE IN NEW MEXICO, LOUISIANA: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE IN NEW YORK, OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STATE REGULATORY FRAUD NOTICES

NOTICE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE IN PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE IN PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NOTICE IN TENNESSEE, WASHINGTON, MAINE, VIRIGINA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE IN ALL OTHER STATES: 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.

P8250028002

UNION BANKERS INS CO ON BEHALF
OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

Forwarding Service Requested

3-DIGIT 290
959 0.7130 AT 0.362
MIKE RUSSELL 7

20111228012S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

[redacted]

ENV 959 1 OF 3 F

Call 888-802-9497 to speak with us
or visit us on the web at www.pennlife.com.

Check Enclosed: Yes
Check Date: 12/28/2011
Check #: 8810788164
Check Amount: 2,500.00

Explanation of Benefits - This is not a Bill

Service Dates -- Service/Provider Benefit Description	Billed Amt	Allowed Amt	Non-Allowed	Policy Deductible/ OOP	Paid Amount	Remark Codes
Claim #: 0080900062 **Patient Name:** MIKE RUSSELL **Date of Birth:** [redacted]						
Provider: **Patient Acct #:** **Policy No:** [redacted]9360						
12/01/11 - 12/31/11 -- TOTAL DISABILITY BENEFITS	2,500.00	2,500.00	0.00	0.00	2,500.00	471
Claim Totals:	2,500.00	2,500.00	0.00	0.00	2,500.00	

Remark Codes:

471 THIS CLAIM WAS CONSIDERED UNDER THE ACCIDENT PORTION OF YOUR POLICY

NOTICE

We are making your benefit determination based upon the information that we have received. This determination is being made without admitting liability while reserving our rights under your policy provisions, and the laws of your state. You or your authorized representative have the right to appeal the Company's benefit determination of the referenced claim. To file an appeal, please write to the Company at: UNION BANKERS INSURANCE CO ON BEHALF OF PENNSYLVANIA LIFE INSURANCE CO PO BOX 130 PENSACOLA, FL 32591-0130 Attention: Claim Appeals.

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY
ON BEHALF OF PENNSYLVANIA LIFE INS CO
PO BOX 130
PENSACOLA, FL 32591-0130

BANK OF AMERICA
ATLANTA, GA
64-1278/611

CHECK NO: 8810788164
CHECK DATE: 12/28/2011

AMOUNT
*****$2,500.00

PAY Two Thousand Five Hundred Dollars

TO THE ORDER OF MIKE RUSSELL

Void if not Cashed Within 90 Days

VOID

[redacted]

PLIC 0536

PS2300280007
20111228012S

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 F
ENV 959

Dependent Name:

CLAIMANT'S REPORT

Telephone Number	Home		Age:	Claim No: Policy No:
	Work			

1. Describe the conditions causing your disability.	
2. What is the name and address of all physicians currently treating you?	
3. On what dates were you treated since completing our last report?	
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).	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?	
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:

DATE: _____ SIGNATURE _____

ADDRESS: _____

PB250028007

20111230125

UNION BANKERS INSURANCE COMPANY
On behalf of
Pennsylvania Life Insurance Company

UNION BANKERS INSURANCE COMPANY ON BEHALF OF PENNSYLVANIA LIFE INSURANCE COMPANY

Executive Offices: P.O. 12355, Pensacola, FL 32591-2355 Toll Free 1-800-275-7366

2 OF 3 B

ENV 959

ATTENDING PHYSICIAN'S SUPPLEMENTAL REPORT

1. Diagnosis of current condition. ICD CODE:	
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:
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?	
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

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Ind. Practitioner's Soc. Sec. #

All Other - Employer I.D. #

Must be furnished under authority of the law

DATE: _____ SIGNATURE _____

ADDRESS _____ TELEPHONE _____

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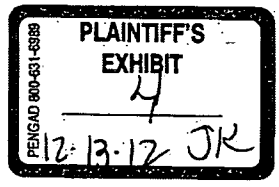


Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Initial Application Dated 11/19/1999.
2. Application Supporting Documents.
3. Underwriting Documents.

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICE: 1010 Wydiff Road, Raleigh, North Carolina 27607

APPLICATION FOR INSURANCE

DATE M M D D Y Y Y Y: 11/9/1999

MAIL PREMIUM NOTICES: ☐ BUSINESS ☒ RESIDENCE ☐ INCREASE

NOV 24 1999

POLICY NO. [redacted]9360

☑ NEW ☐ CURRENT

POLICYHOLDER

INSURED NAME

LAST: [illegible] SUFFIX: FIRST: Alice MI: SOCIAL SECURITY NUMBER: [redacted]

ADDRESS (Street/Rural Route): ADDRESS (Line 2):

CITY: STATE: ZIP CODE: COUNTY:

AREA CODE/ TELEPHONE: BEST TIME/ DAY TO CALL: AM AGE: 28 BIRTHDATE (MMDDYYYY): [redacted] STATE OF BIRTH: IL SEX: F

HEIGHT (Ft. In.): 5 10 WEIGHT: 170 WEIGHT CHANGE LAST 12 MONTHS: NONE ☒ GAIN ☐ LOSS ☐ NUMBER OF LBS: REASON:

OCCUPATION: Sitter CLASS: 2A Average Monthly Salaried Earnings (Gross): Average Monthly Self-Employed Earnings After Expenses: 9166 EXACT DUTIES: Sitting Houses

EMPLOYER: SELF AREA CODE/ TELEPHONE: Same HIRE DATE: 5yrs

EMPLOYER ADDRESS (Street/ Rural Route): Same CITY: Same STATE: ZIP CODE:

BENEFICIARY NAME: Susan 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)

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
04413	17111	ACT						282.50

P-A-1900 SC Rev. II 4.95

PLIC 0542

FORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 [X] 1941 [ ] Benefit / Elimination Insured [L] [67] Spouse [ ] [ ] 734	2000 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 [X] 1944 [ ] 11.5	1000 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 [ ]	per day	per day	
ACCIDENTAL DEATH 1903 [X] 1943 [ ] 2370	25000 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)	$ 76925	$	$
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	$ 1500		
SUBTOTAL	$ 78425	$	$
WAIVER OF PREMIUM [ ] YES	$		
(Waiver of Premium will apply to any Monthly ADB Riders included)			TOTAL MODE PREMIUM:
TOTAL PREMIUM - ALL COVERED INSUREDS (factor)	$ 104305		$ 9387
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

PLIC 0543

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.

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 of Licensed Agent — Agent # 11111

Signature of Licensed Agent — Agent #

Application Signed in:

Columbia — SC — 11/15/99

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 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

PLIC 0545

PENNSYLVANIA LIFE INSURANCE CO.

RECEIVED
NOV 24 1999
NEW BUSINESS DEPT.

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. 10 DAY 15 YEAR 99

POLICY NO. (if applicable) [redacted]9360

Date of Birth: MO. DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: ~~Brad~~ 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 $ 259.00

Premium Mode 23.29

Amount Paid With Application 69.87

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 _____ Agent Code 171111

Signature of 2nd Agent _____ Agent Code _____

Dated at _____ City _____ 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 _____

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
Y4413	01111		ast				69.87

P-A-300 Ed. 3-97

PLIC 0546

A & H APPLICATION RECEIPT

SECTION A

MEDICAID ELIGIBILITY

(To be completed when the "Medicaid Eligibility" question is not on the application.)

DO YOU HAVE A CURRENT MEDICAID ELIGIBILITY CARD?

YES ☐ NO ☒

Applicant's Signature	Date	Agent's Signature
[signature]	11/15/99	[signature]

SECTION B

CERTIFICATION OF DELIVERY

1. ☐ Outline(s) of Coverage for the Insurance applied for.

   (To be completed when an Outline of Coverage is given to the Applicant.)

2. ☐ "Guide to Health Insurance for People with Medicare" booklet.

   (To be completed when the "Buyer's Guide" is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

3. ☐ Medicare Duplication of Coverage Notice.

   (To be completed when the Notice is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

I acknowledge receipt of the items checked above.

Applicant's Signature	Date	Agent's Signature

For Instant Issue only, complete the following:

Policy Number: _____

Rider Control Number: _____ _____ _____

ATTACH TO APPLICATION

Form MC-200(SC) Ed. 8-96

PLIC 0547

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

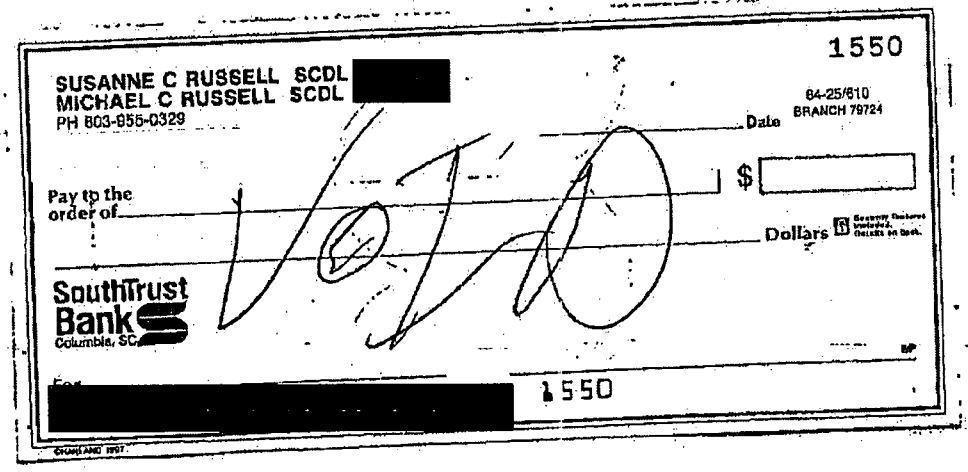
(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
James Lillie, Secretary



P-688

12.98

PLIC 0548

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK	South Trust Bank
CITY, STATE & ZIP CODE	West Columbia SC 29172
NAME OF ACCOUNT	Michael Russell

6Y – 0025

[redacted] ACCOUNT NO.

0610

BANK ROUTING NO.

11-18-98 X Michael Russell

DATE SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

11 (Month) 18 (Day) 98 (Year) on Michael Russell (Name of Proposed Insured)

___ (Month) ___ (Day) ___ (Year) on ___ (Name of Proposed Insured)

___ (Month) ___ (Day) ___ (Year) on ___ (Name of Proposed Insured)

___ (Month) ___ (Day) ___ (Year) on ___ (Name of Proposed Insured)

B.

NB RNWL

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

☐ ☐ Policy Number ___ effective for premiums due on and after ___ (Month) (Day) (Year)

R-688 12.98

(COMPANY COPY)

PLIC 0549

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: P.O. Box 10234, Raleigh, North Carolina 27605

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at P. O. Box10234, Raleigh, North Carolina 27605-0234.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 ½) years.

Signed this 19 day, month of November, 1999

	[signature]
Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PLIC 0550

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) Russell Mike		A. GROSS INCOME LAST YEAR 160,000
TITLE Sider		B. OPERATING EXPENSES LAST YEAR 50,000
DUTIES Siding Homes		A – B = NET INCOME LAST YEAR 110,000
YEARS IN BUSINESS 5yrs		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 5.	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] 17111
Signature of Licensed Agent — Agent #

Signature of Licensed Agent — Agent #

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.

[signature]
Signature of Applicant

Application signed at:

Columbia SC, 11/15/95
City/State — Date

MCF-416 ED. 4-95

PLIC 0551

SUBMISSION ABSTRACT 11-20-99

PENN LIFE INSURANCE
UNDERWRITER -
LANGUAGE IND-

PA01679360 MIKE RUSSELL U 27 [redacted]

29172

APP. DATE
11-19-99
DATE REC'D
11-20-99

							** STATUS **	
1903ADB	AA	25,000	23.75	11-19-99	27	11-72	NFO	NO VALUE
PF1	100	1.0000	15.00			11-72	DIV OP	NONE
1904SURG	AA	1,000	11.50	11-19-99	27	11-72	OTH OP	NONE
1901DIS	AA	2,000	734.00	11-19-99	27	07-72	CWA	282.00
301-1900RP	AA	100	258.80	11-19-99	27	11-19	CWA-DT	11-20-99
							APPVD	NO
							SOURCE	NEW
							STATUS	PENDING
							AMEND	NO
							BASIS	AS APP FOR
							L-TRAN	11-20-99

TOTAL FACE 28,100

						CURRENT
PAC	MTH	19	-1	1043.05	542.39	276.41	93.87	93.87

ROTHEMICH, JON 171111 0 01 100 012-30.0 999- 3.0
NAME NOT ON FILE 1 SC00044413 0 10 100 012-70.0 060-15.0 120-10.0
ROTHEMICH, JON 171111 1 01 100 012-15.0
NAME NOT ON FILE 1 SC00044413 1 10 100 012-50.0

UNDERWRITING AND ADMINISTRATIVE MESSAGES

REQUIREMENT	PERSON	ORDERED	DEPT	CT	NOTIFY
ONLINE MIB INQUIRY	INSURED	11-20-99	99000	0	12-20-99
11-20-99 12.15.04 PM					

RECEIPT	PERSON	ORDERED	DEPT	CT	RECEIVED
NO TABLE ENTRY	INSURED	11-20-99	99000	0	11-20-99

ERR PS SV *** ADMINISTRATIVE MESSAGES
347 130 1 ADDTL BILLING DATA REQUIRED BILLING CTL - TRANSIT INVALID

ERR PS SV *** UNDERWRITER MESSAGES
179 003 0 RIDER NOT ALLOWED WITH BASIC COVERAGE

PLIC 0552

[redacted]9360 INSURED: RUSSELL,MIKE, UND: 11-22-99

544 010 R NFD
RUSSELL, MIKE
[redacted]9360
ILL

PLIC 0553

DEPARTMENT CODE RUN DATE 11/22/99

ALPHA INDEX STATUS REQUEST

PAGE NO. 1

NAME (LAST, FIRST, M.I., SUF.)	PCT	POLICY NUMBER	FILE-COMP. CODE	BIRTH MO	BIRTH DAY	BIRTH YR	STATE (PROV.)	ZIP CODE (POSTAL)	5 - POS. ADDRESS	SEX	(ISSUED) MO	(ISSUED) DAY	(ISSUED) YR	PTD MO	PTD DAY	PTD YR	
RECORD REQUEST																	RECORD REQUEST
RUSSELL,MAUDE	10	[redacted]4651	SP				40	37643	RT 10	M	07	05	70	10	05	97	
RUSSELL,MARY E	10	[redacted]9277	SP				40	37303	C/O I	M	11	05	69	11	05	81	
RUSSELL,MARGARETE L	10	[redacted]6658	GP				40	37716	123 W	F	05	10	72	08	10	84	
RUSSELL,M D	14	[redacted]6280	DP				38		207 W	M	10	29	69	11	01	71	
END OF DATA																	

RECORDS MATCHED

RECORDS MATCHED

FORM 138 REV. 10/74

PLIC 0554

ROA 2278

UNDERWRITING WORKSHEET

Initial Evaluation

POLICY NO: [redacted] 9360

MIB CODES ☐YES ☒NO INDEXING ON REVERSE SIDE ☐YES ☒NO

L70 Alpha Hit ☐YES ☐NO

REFERRED TO MEDICAL UNDERWRITER BY JET ☐N/A ☐YES ☐NO

IF YES, REASON _____

Requirement	ORD	REC	REV	Comment
IR				
MVR				
APS				
Blood / Oral / DBS				
HOS				
Letter				
Other				

FINAL ACTION

Approved as Applied ☒YES ☐NO

Approved with Impairment Rider(s) _____

Approved with Ratifications _____

☐Cancelled ☐Incomplete ☐Declined

Reason _____

OK TO ISSUE $2,000
D15/ACCIDENT

MIB CODES

Und Initials

UND [redacted] Date 11/1/99

2ND [redacted] Date 11/1/99

PLIC 0555

FINAL DISP ABSTRACT 12-06-99

PENN LIFE INSURANCE
UNDERWRITER -- JL
LANGUAGE IND-

[redacted]9360 CTL-[redacted]
MIKE RUSSELL U 27 [redacted]

DEC 07 1999

APP. DATE
11-19-99
DATE REC'D
11-20-99

							** STATUS **	
1903ADB	AA	25,000	23.75	11-19-99	27	11-72	NFO	NO VALUE
PF1	100	1.0000	15.00			11-72	DIV OP	NONE
1904SURG	AA	1,000	11.50	11-19-99	27	11-72	OTH OP	NONE
1901DIS	AA	2,000	734.00	11-19-99	27	07-72	CWA	282.00
301-1900RP	AA	100	258.80	11-19-99	27	11-19	CWA-DT	11-20-99
							APPVD	YES
							SOURCE	NEW
							STATUS	ISSUED
							AMEND	NO
							BASIS	AS APP FOR
							L-TRAN	12-06-99

TOTAL FACE 28,100

						CURRENT
PAC	MTH	19	-1	1043.05	542.39	276.41	93.87	93.87

ROTHEMICH, JON 171111 0 01 100 012-30.0 999- 3.0
NAME NOT ON FILE 1 SC00044413 0 10 100 012-70.0 060-15.0 120-10.0
ROTHEMICH, JON 171111 1 01 100 012-15.0
NAME NOT ON FILE 1 SC00044413 1 10 100 012-50.0

UNDERWRITING AND ADMINISTRATIVE MESSAGES

ERR PS SV *** UNDERWRITER MESSAGES
APPROVED AS APPLIED

PLIC 0556

Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Application for Increase Dated 06/27/2002.
2. Application Supporting Documents.
3. Underwriting Documents.
4. Schedule Page

1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

JUL 09 2002

APPLICATION FOR INSURANCE

POLICYHOLDER

DATE (M M D D Y Y Y Y): 06 27 2002

MAIL PREMIUM NOTICES: ☐ BUSINESS ☑ RESIDENCE ☑ INCREASE

POLICY NO. [redacted] 9360

☐ NEW ☑ CURRENT

INSURED NAME

LAST	SUFFIX	FIRST	MI	SOCIAL SECURITY NUMBER
Russell		Michael		[redacted]

ADDRESS (Street/Rural Route) | ADDRESS (Line 2)

CITY | STATE | ZIP CODE | COUNTY

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: 21A | Average Monthly Salaried Earnings (Gross) | Average Monthly Self-Employed Earnings After Expenses: 7500 | EXACT DUTIES: Res. home - Siding

EMPLOYER: Self | AREA CODE/ TELEPHONE: 803 513 0575 | 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
04442	517346	RGI						8290

P-A-1900 SC Rev. II 4.95

PLIC 0558

FORM SERIES 1900 - ACCIDENT AND/OR SICKNESS RIDERS

BENEFIT	INSURED	SPOUSE	CHILDREN
DISABILITY ACCIDENT* 1901 ☑ 1941 ☐ Benefit: Insured L, Spouse; Elimination: 07 — 183.50	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 ☐ — 50.4	4000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946) — 39.50	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	$		
SUBTOTAL	$ 27380	$	$
WAIVER OF PREMIUM ☐ YES	$ 4548.92	113.17	TOTAL MODE PREMIUM: 41350
(Waiver of Premium will apply to any Monthly ADB Riders included)		(INC ROP 90.33)	
TOTAL PREMIUM - ALL COVERED INSUREDS (Includes Inflation, Waiver and any Monthly ADB Premium)	$ 36415		$ 13 (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

PLIC 0559

ROA 2283

COMPLETE FOR ALL COVERAGES - /E 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	Penn Life	#	[redacted]9360	

PLIC 0560

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 6/20/02
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

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. 6 DAY 27 YEAR 02

POLICY NO. (if applicable) [redacted]9340 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 11 2002

NEW BUSINESS

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		RGIL				20.50

P-A-300 Ed. 3-97

PLIC 0562

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 $120,000
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 0563

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

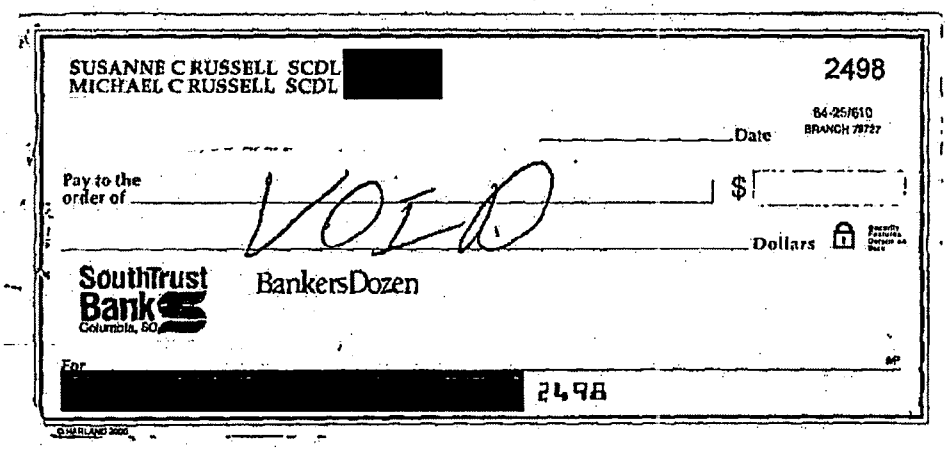
(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
J. Peter Kusev, Secretary



12.98

P-688

PLIC 0564

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: SouthTrust Bank

CITY, STATE & ZIP CODE: Columbia SC

NAME OF ACCOUNT: Suzanne C Russell ; Michael C Russell

6 4 – ☐ ☐ 2 5 [redacted] ACCOUNT NO.

☐ 4 1 0 BANK ROUTING NO.

6/27/02 [signature] SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

DATE

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

6 (Month) 27 (Day) 02 (Year) on Mike Russell (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

(Month) (Day) (Year) on (Name of Proposed Insured)

B.

NB ☐ RNWL ☑ Policy Number [redacted] 936d effective for premiums due on and after 8 (Month) 19 (Day) 02 (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) (Day) (Year)

P-688 12.98

(COMPANY COPY)

PLIC 0565

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this 29th day, month of June 2002

	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	
	Signature of Spouse if to be Insured
Name of Minor Child	

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PLIC 0566

ROA 2290

A & H APPLICATION RECEIPT

SECTION A

MEDICAID ELIGIBILITY

(To be completed when the "Medicaid Eligibility" question is not on the application.)

DO YOU HAVE A CURRENT MEDICAID ELIGIBILITY CARD?

YES ☐ NO ☑

Applicant's Signature | 6/27/02 Date | Agent's Signature

SECTION B

CERTIFICATION OF DELIVERY

1. ☐ Outline(s) of Coverage for the Insurance applied for.

   (To be completed when an Outline of Coverage is given to the Applicant.)

2. ☐ "Guide to Health Insurance for People with Medicare" booklet.

   (To be completed when the "Buyer's Guide" is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

3. ☐ Medicare Duplication of Coverage Notice.

   (To be completed when the Notice is given to an Applicant age 65 or over. This includes any person to be covered who is age 65 and over.)

I acknowledge receipt of the items checked above.

Applicant's Signature | Date | Agent's Signature

For Instant Issue only, complete the following:

Policy Number: _____

Rider Control Number: _____ _____ _____

ATTACH TO APPLICATION

Form MC-200(SC) Ed. 8-96

PLIC 0567

PENNSYLVANIA LIFE INSURANCE COMPANY
HOME OFFICE: Wayne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

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) Russell Mize		A. GROSS INCOME LAST YEAR 420,000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 330,000
DUTIES Install Hard Siding		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS 6		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 8	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 of Licensed Agent — Agent # 173416

Signature of Licensed Agent — Agent #

Application signed at:

Lexington SC / 7/8/05

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 of Applicant

MCF-416 NC-P ED 4-95

PLIC 0568

DEPARTMENT CODE RUN DATE 07/10/02

ALPHA INDEX STATUS REQUEST

PAGE NO. 1

NAME (LAST, FIRST, M.I., SUF.)	PCT	POLICY NUMBER	FILE-COMP CODE	BIRTH MO	BIRTH DAY	BIRTH YR	STATE (PROV)	ZIP CODE (POSTAL)	5 - POS. ADDRESS	SEX	ISSUED MO	ISSUED DAY	ISSUED YR	PTD MO	PTD DAY	PTD YR	
RUSSELL, MIKE RECORD REQUEST	14	PA0167[redacted]9360	KP	07	07	72	38	29172	1459	M	07	19	02				SEARCH DATE 07/10/02 RECORD REQUEST
RUSSELL,MIKE	28	[redacted]9360	KP	[redacted]			38	29172		M	11	19	99	07	19	02	
RUSSELL,M D	14	[redacted]6280	DP				38		207 W	M	10	29	69	11	01	71	
END OF DATA																	

RECORDS MATCHED

RECORDS MATCHED

FORM 138 REV. 10/74

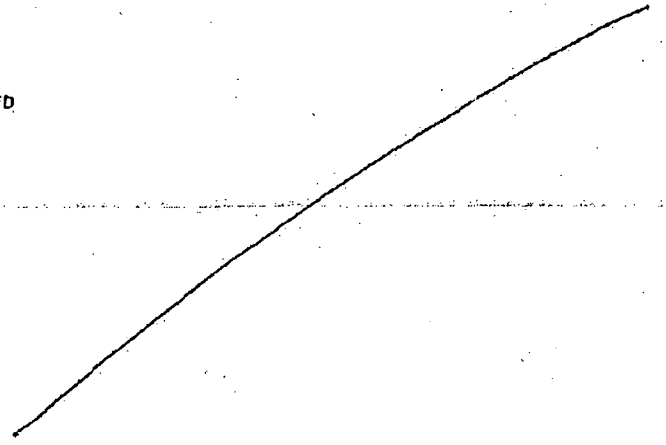
ROA 2293

PLIC 0569

[redacted]9360 INSURED: RUSSELL,MIKE. UND: 07-10-02

544 010 R NFD
RUSSELL, MIKE
[redacted]9360
[redacted] ILL

877 001 R NFD
RUSSELL, MIKE
[redacted]9360
[redacted] ILL



PLIC 0570

rep me

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: siding sleep 5 2A Income: $7500/M MIB: Yes (No)

Life: 1904 → $40000/- Critical Care: 1946 $50/-

A&H: ACC: 500/M 1-7EP Sickness: 1903 → $750 LTC / HHC: _____

Medical History on Application: effective 11/99
NO TIR
NIC

Requirement Findings: no declared Med hx

see over ☐

Final Action:

7/25/02
Ins approved
R

MIB Codes: _____ / _____ / _____

U/W: _____ Date: _____ Second Review: _____ Date: _____

UND-199 3.01

PLIC 0571

APPLICATION WORKFLOW SHEET

Policy No: [redacted]93600 Add File History on Reverse Side: Yes / No

REQUIREMENTS

Type	Req'd	Ord'd	Rec'd	Rev'd	Type	Req'd	Ord'd	Rec'd	Rev'd
Blood					HOS				
Oral					Paramed				

	Req'd	Ord'd	Rec'd	Rev'd	Comments
IR					
MVR					
Letter					
Other					
APS					

Underwriter: _____ **FINAL DECISION** Date: 7/25/02

APPROVED ☒ CONDITIONAL ☐ RATED _____

DECLINED ☐ INCOMPLETE ☐ WITHDRAWN ☐

☐ Impairment Rider _____ ☐ Ratification/Amendment _____

ASSEMBLY: Code 99 ☐ InsLtr ☐ Und164/Wisc ☐ MIB ☐ Occupational ☐ Replacement ☐

Signed App / Medic ☐ Keyfacts/Hooper/Eqfax ☐ Refund / Balance Due _____

Other: _____

REINSURANCE: Co. _____ Auto: Yes / No

Existing $_____ Ceded $_____ Retained $_____

NOTES: _____

UND-203 8.01

PLIC 0572

(1) 60D6 - CHECK FOR APPROVAL INSTRUCTIONS & OTHER NOTES
CHANGES Approved 7/25/02

(2) 62D1 - CONSOLIDATED INFORCE
(Historied Riders on 62D2) NONE

PTD / BLDY 8/19/02

SUSPENSE NONE

MODE PAC

CHANGES NONE

(3) 60D1 - VERIFY PTD; CWA; PAC INFORMATION
CHANGES NONE

(4) 60D2 - VERIFY NEW AND OLD COVERAGE
CHANGES NONE RIDERS 4, 5, 6, 7, 8

(5) 60D3 / 6002 - VERIFY AGENT INFORMATION / CONFIRM ADVANCE
CHANGES NONE

(6) 60D4 - VERIFY BAL DUE / REFUND-CHEQUE / CORRECT ERRORS IF NEEDED
CHANGES NONE GILL, RANDOLPH 173416 PHS 2,344 OK

(7) 60D5 - VERIFY REQUIREMENT & CONFIRM CURRENT DATES OK

(8) 60D7 & 60D8 - VERIFY FOR ACCURACY OK

(9) SYSTEM APPROVALS
55KW UNDERWRITER _____
CONDITIONAL _____

56KW,, ISSUE 7/25/02 OK BT

OUTSTANDING REQUIREMENTS

BAL DUE _____ RAT _____ OTHER _____
REFUND _____ IMPAIR _____
UND 164 _____ DUPLICATE _____ REISSUE _____ CODE 99 _____

ASSEMBLY INSTRUCTIONS

NOTEPAD YES _____ NO _____

ASSEMBLE & MAIL _____
ASSEMBLE & RETURN TO _____
DO NOT ASSEMBLE & RETURN TO _____
SPECIAL INSTRUCTIONS _____

ZAH-523 9.98

PLIC 0573

60CW, [redacted]9360; RUSSELL, MIKE POLCY CHG ISSUED 07/25/02
UNDRWRTR=SMG CLERK= FILELOC=HMOFF AGY=091477 /

TYPE	ENTRY	AS-OF	SRC	DES	AMOUNT	DPDSK	DEPOSIT BATCH / MISC.
REG	0710	062702	00	01	82.90	HOP26	0710 NO BATCH ASSIGNED
							D-2180000 C-2182550
					82.90		** TOTAL **

D1-STATUS
D2-COVRAGE
D3-AGENTS
D4-ERRORS
D5-PND REQ
D6-NOTES
D7-PEOPLE
D8-ADDRESS
D9-ALLOCAT
CW-CWA DSP
XX-SEG ID

! 19 READY FOR NEXT TRANSACTION ! CICSP10 00

PLIC 0574

SUBMISSION ABSTRACT 07-10-02

PENN LIFE INSURANCE
UNDERWRITER -
LANGUAGE IND-

CTL-[redacted]
[redacted]9360 MIKE RUSSELL U 27 [redacted]
1469 DOGWOOD RD
W COLUMBIA SC 29172

PAID TO
07-19-02
BILLED TO
07-19-02

							** STATUS **	
1903ADB	AA	25,000	23.75	11-19-99	27	11-72	NFO	NO VALUE
PF1	100	1.0000	15.00			11-72	DIV OP	NONE
1904SURG	AA	1,000	11.50	11-19-99	27	11-72	OTH OP	NONE
1901DIS	AA	2,000	734.00	11-19-99	27	07-72	CWA	NONE
301-1900RP	AA	100	258.80	11-19-99	27	11-19	APPVD	NO
							SOURCE	POLICY CHG
							STATUS	PENDING
							AMEND	NO
							BASIS	AS APP FOR
							L-TRAN	07-10-02

TOTAL FACE 28,100

							CURRENT
PAC	MTH	19	-1	1043.05	542.39	276.41	93.87	93.87

		170106	0	00	100	012- 3.0		
NAME NOT ON FILE	1	171111	0	01	100	012-30.0	999- 3.0	
NAME NOT ON FILE	1	SC00044413	0	10	100	012-70.0	060-15.0	120-10.0
		170106	1	00	100	012- 1.5		
NAME NOT ON FILE	1	171111	1	01	100	012-15.0		
NAME NOT ON FILE	1	SC00044413	1	10	100	012-50.0		

UNDERWRITING AND ADMINISTRATIVE MESSAGES

ERR PS SV *** ADMINISTRATIVE MESSAGES
CREATED BY REVERSE RECORD BUILD TXN - HO

ERR PS SV *** UNDERWRITER MESSAGES
179 003 0 RIDER NOT ALLOWED WITH BASIC COVERAGE
APPROVED AS APPLIED

PLIC 0575

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 DATE
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)

PLIC 0576

Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Signed Request, dated 06/28/2006, to Change Bank Draft Account.
2. Voided Check for New Account.

BARB, SNYDER & COMPANY, LLC
1751 ST. JULIAN PLACE
COLUMBIA, SC 29204
803.252.0606

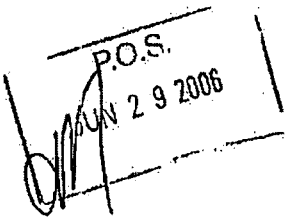
Date: June 28, 2006

Attention: Customer Service

Fax Number: 905-795-2316

From: Mike Russell

Our Fax Number: 803.252.0062



Message:[1] Attached is a voided check from my new business account. I would like to have my monthly premium draft of $260.02 moved to this account. My policy # is [redacted]9360. If you have any questions please contact my wife, Susanne Russell at 803-252-0606 or email me at susanne@sc-cpa.com. Thank you for your help.

Mike Russell

FILE COPY

[1]**Confidentiality Notice**
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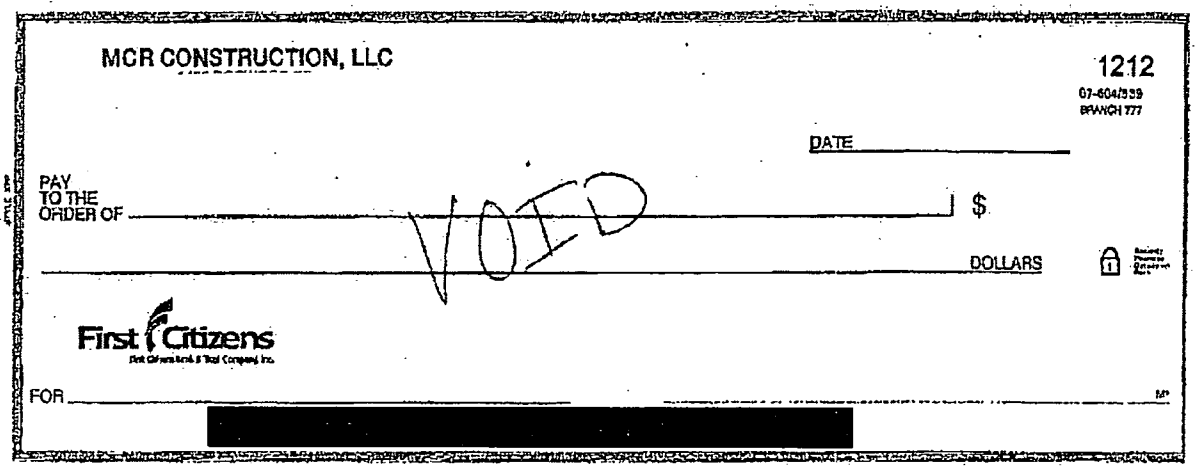
Circular 230 Notice
We are required by the Internal Revenue Service (IRS) Circular 230 to inform you that any tax advice contained in the body of this document was not intended or written to be used, and cannot be used, by the recipient or any other taxpayer for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code or applicable state or local tax law provisions. This reliance paragraph applies to any and all attachments applicable to this document.

In December 2004, the U.S. Treasury Department and the IRS modified Treasury 230 to provide standards for covered opinions and other written advice provided by tax professional practicing before the IRS. The final regulations have recently become effective. If you have questions regarding this notice or reliance paragraph, please contact us.


MCR CONSTRUCTION, LLC

1212

07-604/339
BRANCH 777

DATE

PAY
TO THE
ORDER OF

$

VOID

DOLLARS

First Citizens

FOR

[redacted]

PLIC 0579

Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Change of Benefits Agreement Signed 7/20/2009. **{the request is to remove ROP benefit riders effective 4/20/2009}**
2. All Supporting Documents, from PHS, for ROP removal.
3. ROP Removal Letter dated 08/31/2009, with copy of Refund Check of Unearned Premium.

PENNSYLVANIA LIFE INSURANCE CO.

CHANGE OF BENEFITS AGREEMENT

I acknowledge the fact that I have changed my coverage on policy # [redacted]9360 as follows:

☐ I am reducing my basic policy coverage from _____ to _____.

☐ I am reducing my existing rider(s) that were effective _____ from _____ to _____.

☒ I have deleted benefit rider(s) that were effective:

301 0066
T.O.A.
Dated 11/19/99 & 7/19/2002
8/19/99

Effective Date of Changes 9-20-09.

Insured's Signature

7-20-09
Date

Michael Russell

II-19 (MC) Original - *Home Office* Yellow - *Processing Office* Pink - *Insured* 7.96

IMAGING
AUG 11 2009

ROA 2305

PLIC 0581

UNIVERSAL AMERICAN FINANCIAL CORP.

KEY; INTER-COMPANY CODES

01-Peninsular	11-Union Bkrs	19 - Marquette	22- Progressive	25-UAFC
		20 - Pyramid	23- Exchange	
02 - Penn Life	12-Constitution	21- Pioneer	24-WorldNet	27 - CHCS SERVICES, INC.

Check Requisition - US ONLY

[X] 03 - UNIVERSAL AMERICAN FINANCIAL SERVICES, INC. (SERVICE COMPANY)

Vendor Id:
Name/Company: MIKE RUSSELL
Attn:
Addr1:
Addr2:
City/State/Zip
1099 [ ] Federal ID #
1099 vendors require Federal Tax ID and full address.

Requested By: [redacted] PNB27
Date: 8/18/2009
Authorized By:
Date:

Please sign with *non-black ink*.
Thank you.

Invoice Date: 19-Aug
Invoice Nbr: MJC
Amount: $ ~~64.54~~

Check Description: [redacted]9360 24 Characters - this information will appear on the check stub
Invoice Due Date: (Date MUST match the due date of the invoice for search criteria)
Pay Date: (Date you want invoice paid)

Account	AGENT	BCTR	DM	LOB	LOBR	STATE	INTCO	ZIP	SUSPENSE	Amount DB/(CR)	Transaction Description (19 Characters)
[redacted]	N	N	N	49800	2	SC	N	N	[redacted]9360	$ 71.73 ~~64.54~~ MJC	Refund of Unearned Premium

Segment codes (LOB): See Attached L.O.B. Listing

$ 71.73 ~~64.54~~ MJC ! Amounts must match or request cannot be processed

Check Instructions:

[XX] Return to Requestor [ ] Mail Directly to Vendor w/attchd support

* THE INTER-COMPANY FIELD SHOULD BE USED WHEN PAYING CORPORATE DIRECT EXPENSES OUT OF THE SERVICE COMPANY; INDICATE THE COMPANY THAT SHOULD BE CHARGED.

ROA 2306

PLIC 0582

62D1 [redacted]9360; .AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

* NOTES

IST-SC RST-SC AREA-00000 COV-LAP-SP-BILL SUS-STAT-ENT-ASN/O-MEC-PAR-RB-NFO--TRN
A&H SS NBR 411-41-7773 YES 09 19-1 NO 22 GC NO /0 N 1- 0 NONE NO

BIL CTL 1 [redacted]
TRANSIT 6706040539
ACT NO. 083052902001
SIGNOR SUSANNE C RUSSELL
MICHAEL C RUSSELL

INSURED MIKE RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172-2451
(803) 955-0329

BEN(01) SUSANNE RUSSELL,SPOUSE

PLAN- 1903ADB		LAST PREM	CASH
PAC-M	260.02	PAID TO	08/19/09
FACE	25000.00	BILLED TO	08/19/09
CV	.00	ISSUE	11/19/99
OTHER	** NONE **	PAY UP	11/19/72
LOAN	.00	LAST BILL	07/20/09
PYOFF	.00	LAST ACCT	07/20/09
SUSP	.00	LAST OTHR	08/26/02

AGT-171111 -JON ROTHEMICH
GA--888890 -MGR DEV-ATLANTIC REGION
CK620 DISPLAY COMPLETE

08/18/09 PNB27
CICSP10 00

Reversed 1 month 260.02
~~Rem~~ (Removed (3) ROP Rdrs) ~~-95.57~~ -188.29
Applied new prem. ~~64.57~~ $71.73
Fracmode (1 mth.) $

Prem. Ref. due

historied ROPs #4, 9, 12 riders

Eff. 7/19/09

62D2 [redacted]9360; .AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

AGE RTE IS CEASE FACE/UN ANNUAL	* NOTES	
	SUS-STAT-ENT-ASN/O-MEC-PAR-RE-NFO--TRN	
(01)--1903ADB - D10-05000-9-C-K19-03-	NO 22 GC NO /0	N 1- 0 NONE NO
U27 11-19-99 11-72 25,000 23.75	PLAN- 1903ADB	LAST PREM CASH
AE=000 SE=000 AB=LIFE SB=0D	PAC-M 260.02	PAID TO 08/19/09
LOB 49802	FACE 25000.00	BILLED TO 08/19/09
PF1 100 11-72 1.000 15.00	CV .00	ISSUE 11/19/99
	OTHER ** NONE **	PAY UP 11/19/72
(02)3-1904SURG - C10-05000-9-C-G19-04-	LOAN .00	LAST BILL 07/20/09
U27 11-19-99 11-72 1,000 11.50	PYOFF .00	LAST ACCT 07/20/09
AE=000 SE=000 AB=LIFE SB=0D	SUSP .00	LAST OTHR 08/26/02
LOB 49102		
(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		
LOB 49202		

08/18/09 PNB27
CK621 PRESS ENTER TO CONTINUE DISPLAY CICSP10 00

PLIC 0584

62D2, [redacted]9360; .AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

AGE	RTE	IS	CEASE	FACE/UN	ANNUAL
(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					
LOB 49292					
(05)3-1901DIS - A10-05000-9-C-A19-01-					
U30	07-19-02	07-72		500	183.50
AE=007 SE=000 AB=LIFE SB=0D					
LOB 49202					
(06)3-1904SURG - C10-05000-9-C-G19-04-					
U30	07-19-02	07-72		4,000	50.80
AE=000 SE=000 AB=LIFE SB=0D					
LOB 49102					
(07)3-1946EMERG - H10-05000-9-C-Q19-46-					
U30	07-19-02	07-72		50	39.50
AE=000 SE=000 AB=LIFE SB=0D					
LOB 49402					

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	08/19/09
FACE	25000.00	BILLED TO	08/19/09
CV	.00	ISSUE	11/19/99
OTHER	** NONE **	PAY UP	11/19/72
LOAN	.00	LAST BILL	07/20/09
PYOFF	.00	LAST ACCT	07/20/09
SUSP	.00	LAST OTHR	08/26/02

08/18/09 PNB27
CICSP1C 00

PLIC 0585

62D2, [redacted]9360; .AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

AGE	RTE	IS	CEASE	FACE/UN	ANNUAL
(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					
LOB 49802					
(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					
LOB 49292					
(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					
LOB 49202					
PF2	100		07-72	1.000	35.00

* 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	08/19/09
FACE	25000.00	BILLED TO	08/19/09
CV	.00	ISSUE	11/19/99
OTHER	** NONE **	PAY UP	11/19/72
LOAN	.00	LAST BILL	07/20/09
PYOFF	.00	LAST ACCT	07/20/09
SUSP	.00	LAST OTHR	08/26/02

CK621 PRESS ENTER TO CONTINUE DISPLAY

08/18/09 PNB27
CICSP10 00

PLIC 0586

62D2, [redacted]9360; .AS-OF 08/18/09;. 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	
(11)3-1914SURG - C10-05000-9-C-H19-14-			PLAN- 1903ADB		LAST PREM	CASH
U30 08-19-02 08-72	5,000	238.00	PAC-M	260.02	PAID TO	08/19/09
AE=000 SE=000 AB=0D SB=LIFE			FACE	25000.00	BILLED TO	08/19/09
LOB 49102			CV	.00	ISSUE	11/19/99
			OTHER	** NONE **	PAY UP	11/19/72
(12)3-301-1900RP - H10-05000-9-C-Q30-1 -			LOAN	.00	LAST BILL	07/20/09
U30 08-19-02 11-19	100	344.19	PYOFF	.00	LAST ACCT	07/20/09
AE=000 SE=000 AB=LIFE SB=LIFE			SUSP	.00	LAST OTHR	08/26/02
LOB 49292						

CK620 DISPLAY COMPLETE

08/18/09 PNB27
CICSP10 00

PLIC 0587

62D3,[redacted]9360; .AS-OF 08/19/09;. RUSSELL, MIKE M-27 [redacted]

* NOTES

AS-OF 08/19/09						
	ANNUAL	2,889.16	SUS-STAT-ENT-ASN/O-MEC-PAR-RE-NFO--TRN			
	SEMI	1,502.36	NO 22 GC NO /0		N 1- 0	NONE NO
	QUARTER	765.63	PLAN- 1903ADB		LAST PREM	CASH
	MONTHLY	260.02	PAC-M	260.02	PAID TO	08/19/09
	PAC	260.02	FACE	25000.00	BILLED TO	08/19/09
			CV	.00	ISSUE	11/19/99
			OTHER	** NONE **	PAY UP	11/19/72
			LOAN	.00	LAST BILL	07/20/09
			PYOFF	.00	LAST ACCT	07/20/09
			SUSP	.00	LAST OTHR	08/26/02

CK620 DISPLAY COMPLETE

08/18/09 PNB27
CICSP10 00

62D7 [redacted] 9360; .AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

* NOTES

NOT	003	A	04-08-37	65NOT
NOT	003	A	09-10-37	65CEA
NOT	003	A	05-08-42	70CON
NOT	004	A	09-20-19	20NOT
NOT	009	H	07-25-03	CDM53
NOT	009	H	08-26-03	CDM47
NOT	010	A	04-08-37	65NOT
NOT	010	A	09-10-37	65CEA
NOT	010	A	05-08-42	70CON

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 08/19/09
FACE 25000.00 BILLED TO 08/19/09
CV .00 ISSUE 11/19/99
OTHER ** NONE ** PAY UP 11/19/72
LOAN .00 LAST BILL 07/20/09
PYOFF .00 LAST ACCT 07/20/09
SUSP .00 LAST OTHR 08/26/02

CK620 DISPLAY COMPLETE

08/18/09 FNB27
CICSP10 00

PLIC 0589

U1NP, [redacted]9360; . RUSSELL, MIKE 08/18/09

INFORCE NOTEPAD DISPLAY

PURPOSE CODE EXC3U NOTED BY EX 3U ON 08/26/02 PRIORITY 0
SOURCE NEW BUSINESS PURGE ON **/**/**

CREATED BY REVERSE RECORD BUILD TXN - HOP26

PURPOSE CODE UND NOTED BY LU010 ON 08/20/02 PRIORITY 0
SOURCE NEW BUSINESS PURGE ON **/**/**

APPINC
APPROVED AS APPLIED

PURPOSE CODE UND NOTED BY CDN39 ON 07/25/02 PRIORITY 0
SOURCE NEW BUSINESS PURGE ON **/**/**

APPINC
INC APPROVED

CKUL01 - TRANSACTION CONTINUED 08/18/09 PNB27
CICSP10

U1NP [redacted]9360; . RUSSELL, MIKE 08/18/09

INFORCE NOTEPAD DISPLAY

PURPOSE CODE EXC3U NOTED BY EX 3U ON 07/25/02 PRIORITY 0
SOURCE NEW BUSINESS PURGE ON **/**/**

CREATED BY REVERSE RECORD BUILD TXN - HOP26

PURPOSE CODE UND NOTED BY LU005 ON 12/01/99 PRIORITY 0
SOURCE NEW BUSINESS PURGE ON **/**/**

APPROVED AS APPLIED

CKUL00 - REQUESTED TRANSACTION SUCCESSFULLY COMPLETED

08/18/09 PNB27
CICSP10

[redacted]9360; . AS-OF 08/18/09;. RUSSELL, MIKE M-27 [redacted]

COMPLETED ACTIVITY FROM 11/08

TRANSACTION	DUE DATE	AS-OF	AMOUNT	MODE	GEN	DESK	ENTRY
REG PRM	12/19/08	12/19/08	260.02	MTH	AC	PAC	12/19/08
REG PRM	01/19/09	01/19/09	260.02	MTH	AC	PAC	01/19/09
REG PRM	02/19/09	02/19/09	260.02	MTH	AC	PAC	02/19/09
REG PRM	03/19/09	03/19/09	260.02	MTH	AC	PAC	03/19/09
REG PRM	04/19/09	04/19/09	260.02	MTH	AC	PAC	04/20/09
REG PRM	05/19/09	05/19/09	260.02	MTH	AC	PAC	05/19/09
REG PRM	06/19/09	06/19/09	260.02	MTH	AC	PAC	06/19/09
REG PRM	07/19/09	07/19/09	260.02	MTH	AC	PAC	07/20/09

CKUL00 - REQUESTED TRANSACTION SUCCESSFULLY COMPLETED

08/18/09 PNB27
CICSP10

Outstanding Suspense Details (Approved and Unapproved) - Totals by Calendar Period

Company: 106 **Account:** [redacted] **Ending Cal Period:** 2009-08-31

Suspense Status at Cal Period Date / Suspense Match Code	Amount	Source	Txn Date	Reference ID	JE Dtl Status	Accts Pd	JE Dtl Description	Current Suspense Status	Latest Date Susp Status Changed
[redacted]					A			O	
Suspense Match code Total	0.00								
[redacted]									
Suspense Match code Total									
[redacted]					A				05/24/2009
[redacted]			08-24-2009	CK4	A			Outstanding	05/24/2009
[redacted]			08-25-2009	CS203	A			Outstanding	08/25/2009
Suspense Match code Total	0.00								
[redacted]									
Suspense Match code Total									
[redacted]									
Suspense Match code Total									
[redacted]									
Suspense Match code Total									
[redacted]									
Suspense Match code Total									
Outstanding [redacted]9360	-260.02	CK4	08-18-2009	CK4	A	2009-08-31	PA01679360PNB081809	Outstanding	08/18/2009
Suspense Match code Total	-260.02	[redacted]9360							
[redacted]									
Suspense Match code Total									

-188.29
+71.73

PENNSYLVANIA LIFE INSURANCE CO.

A subsidiary of UNIVERSAL AMERICAN FINANCIAL CORP.

August 31, 2009

Mike Russell

RE: Policy No: [redacted]9360

Dear Mr. Russell:

Thank you for your recent request received August 12, 2009, to remove all Return of Premium Riders attached to the above referenced policy.

Please be advised that we have removed the Return of Premium Riders issued November 19, 1999, July 19, 2002, and August 19, 2002, effective July 19, 2009.

This policy is currently paid to August 19, 2009 and the new monthly premium is $195.51.

Enclosed please find our check in the amount of $71.73 which represents a refund of unearned premium.

We appreciate your business and your continued confidence in Pennsylvania Life to meet your insurance needs. We are glad for this opportunity to be of service to you. Should you have questions, or if further assistance is required, please contact our office at 1-800-275-7366.

Sincerely,

Policyholder Services Department
Pennsylvania Life Insurance

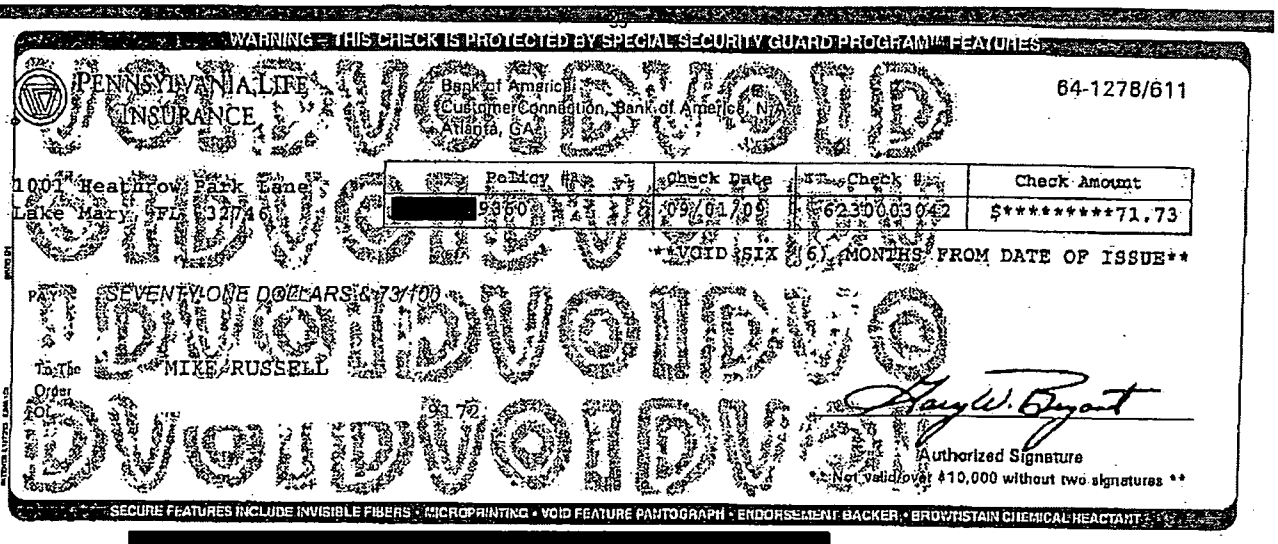
Cc: 044425 / 091477

27

PO Box 130
Pensacola, FL
32591

Tel: 1-800-275-7366
Fax: 1-866-908-8456
E-Mail: CS@Pennlife.Com

For Client Services:
8am – 6pm EST
Mon - Fri



WARNING - THIS CHECK IS PROTECTED BY SPECIAL SECURITY GUARD PROGRAM™ FEATURES

PENNSYLVANIA LIFE INSURANCE

Bank of America
Customer Connection, Bank of America, N.A.
Atlanta, GA

64-1278/611

1001 Heathrow Park Lane
Lake Mary, FL 32746

Policy #	Check Date	Check #	Check Amount
[redacted]9360	09/01/09	6230003042	$**********71.73

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY SEVENTY-ONE DOLLARS & 73/100

To The Order Of MIKE RUSSELL

POL [redacted]170

Gary W. Bryant
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

MIKE RUSSELL
SOURCE CODE POA

CHECK NUMBER 6230003042
CHECK DATE 09/01/09

Ref. Date	Policy #	Description	Check Amount
09/01/09	[redacted]9360		71.73

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

Policy #	Check Date	Check #	Check Amount
[redacted]9360	09/01/09	6230003042	$*********71.73

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVENTY-ONE DOLLARS & 73/100*

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 POA

CHECK NUMBER 6230003042
CHECK DATE 09/01/09

Ref. Date	Policy #	Description	Check Amount
09/01/09	[redacted]9360		71.73

PLIC 0596

Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Calltrack to place policy back on bank draft. Processed 9/30/2009.

New Call Sheet

UNIVERSAL AMERICAN

Call Trak

Home

CALL SHEET

Entered By: Patricia Moye
On: 9/2/2009 2:42:08 PM
Call Number: ca-090209144208
Call Status: Pending
Marked Completed By:
On:
No. of Days Pending: 1

Caller Indentification

Caller First Name: * MIKE
Last Name:* RUSSELL
Caller Phone Number:*
Policy/Agent Number: [redacted]9360
Policy Holder Name:
Caller Relationship: * Policyholder
Company:* Penn Life

Reason For Call

Department For Routing: PHS
Enter Remark: Add

Please review to check status of refund per notes dated 8/18/09 refund pending $64.51. Also should policy be placed back on bankdrft now that riders have been dropped?

Assigned To: Select... Add Comment

Call Back Required? Yes
Caller's Request: - select

Response

Enter Progress Comment: Add

Rachel Bailey at 9/3/2009 11:08:21 AM : syc
Susanna Cushing at 9/3/2009 1:52:48 PM : This req already processed,as I saw tracking note when noted ck mailing.Placed pol back on draft.SYC

Save Mark This Call Completed

placed on PAC 9-3-09 syc

Policy #: [redacted]9360 **Policyholder: Mike Russell**

Documents attached:

1. Claim Payments from 09/22/2008 – 08/26/2010.

RMO4231265

PENNSYLVANIA LIFE INSURANCE COMPANY
BANK OF AMERICA 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

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

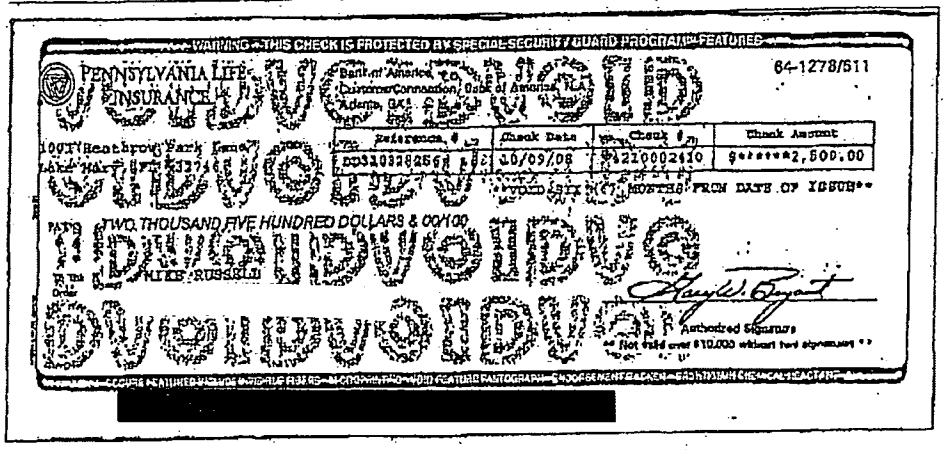
ADJ 8090 STATE 38 S/C 0044413 M/C 091477

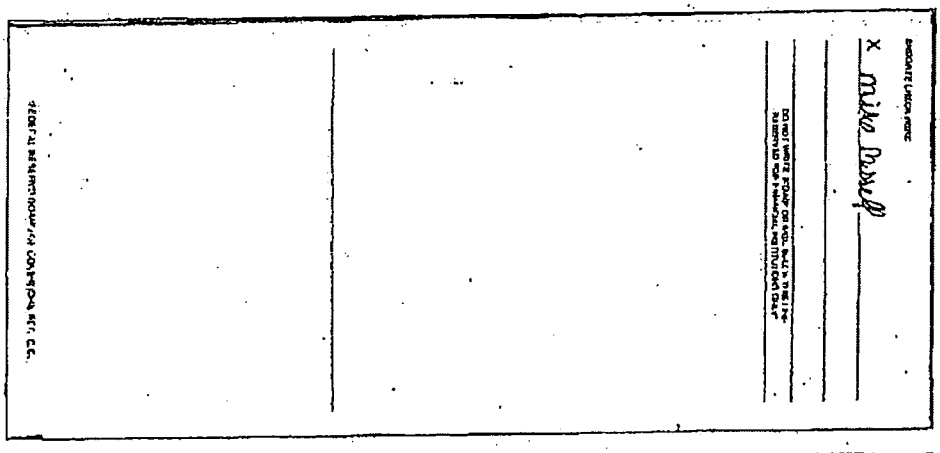
PLIC 0387

PLIC 0600

ROA 2324

6/3/2010 12:11:54 PM





Location	Acct #	Check #	Amount	Paid Date	Sequence	Customer Data
CD	[redacted]	4210002410	$2,500.00	10/20/2008	31944484885	

R/T Number	CD VoiID/CIMS Key	CD Label	Payee Name
6111278	081103402221O1	081103402221O1	

PLIC 0386

PLIC 0601

ROA 2325

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 11-14-08
CLAIM NO. 0809-00052 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 0385

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
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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 12-23-08
CLAIM NO. 0809-00052 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 0064413 M/C 091477

PLIC 0384

PLIC 0603

ROA 2327

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 02-11-09
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 0383

PLIC 0604

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 4210016833
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	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 0382

PLIC 0605

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 04-10-09
CLAIM NO. 0809-00062 REP 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 0381

PLIC 0606

ROA 2330

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 0380

PLIC 0607

PENNSYLVANIA LIFE INSURANCE

1001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
CustomerConnection, Bank of America, N.A.
Atlanta, GA

64-1278/811

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

9172

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. 0809-00052 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 0044613 M/C 091477

PLIC 0379

PLIC 0608

RMO4231265

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

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]3160 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 0378

PLIC 0609

ROA 2333

RMO4231265

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
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

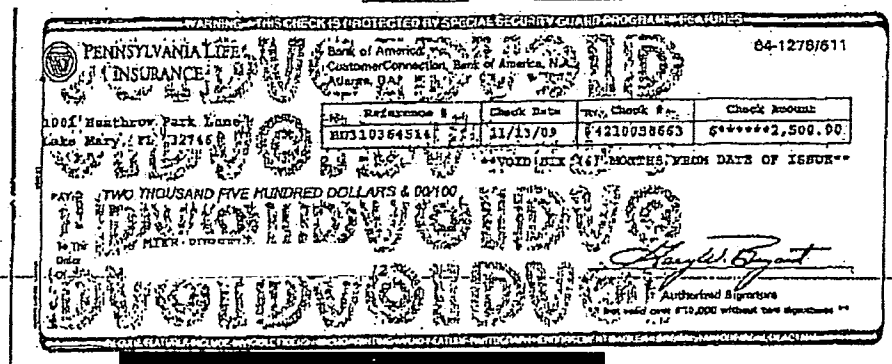
ADJ 8090 STATE 38 S/C 0044413 M/C 091477

PLIC 0377

PLIC 0610

Document type : Disbursement Check

06/03/2010 12:10 PM



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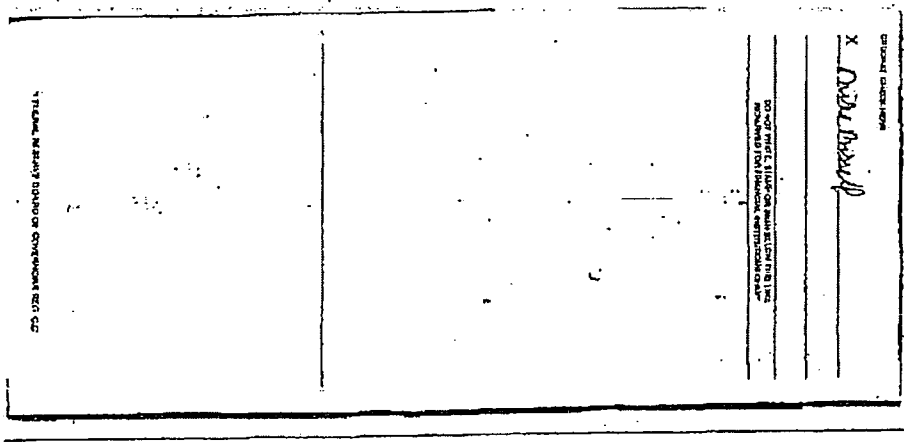


Tag	Note	Item Date	Sequence Number	Account Number
Routing Number	Amount	Serial Number	Image Indicator	Berry Indicator
Customer Data	Payee Name	Volume ID	Account Nums	Issue Date
No	No	11/20/2009	2394675855	[redacted]
0111276	2500.00	4210038663	1	0
		091201000771101		

Bank of America

Page 1/1

PLIC 0376

PLIC 0611

RMO4231265

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
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 01-12-10
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 0375

PLIC 0612

ROA 2336

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
BD3103722 90	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. BD3103722 90

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

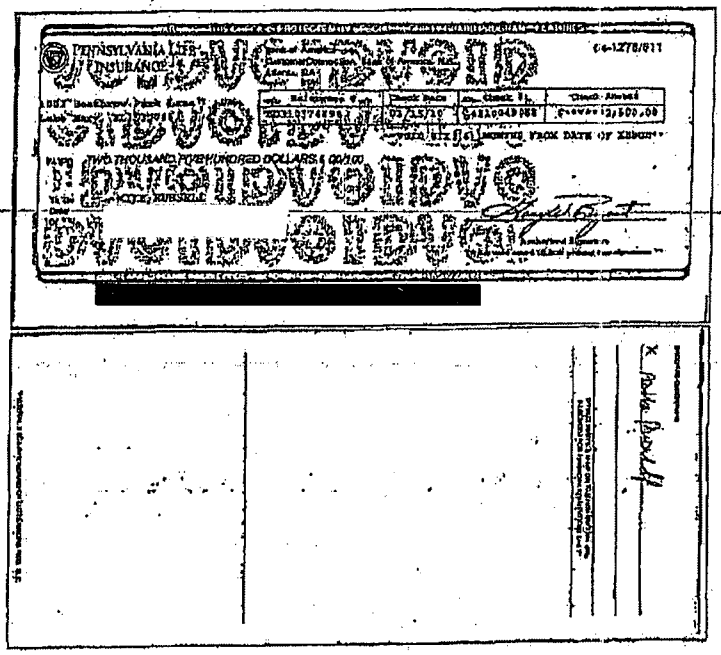
ADJ 8090 STATE 38 S/C D044413 M/C 091477

PLIC 0374

PLIC 0613

Bank of America Higher Standards

Bank of America Direct®



Check Info	
Account:	[redacted]
Amount:	2,500.00
Check #:	4210049058
Posted Date:	03/24/2010

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RMO4231265

PENNSYLVANIA LIFE INSURANCE

2001 Heathrow Park Lane
Lake Mary, FL 32746

Bank of America
Customer Connection, Bank of America, N.A.
Atlanta, GA

64-1278/611

Reference #	Check Date	Check #	Check Amount
BD310374898	03/15/10	4210049058	$******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 4210049058
CHECK DATE 03/15/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 03-15-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310374898

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	01-25-10	02-25-10	1MO	2000M	2,000.00
	TOTAL DISABILITY	01-25-10	02-25-10	1MO	500M	500.00
				TOTAL THIS PAYMENT		2,500.00
				TOTAL PAID TO DATE		53,125.00

PARTIAL PAYMENT

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

PLIC 0388

PLIC 0615

ROA 2339

RMO4231265

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
BD310385246	07/20/10	4210059426	$******7,500.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *SEVEN 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 4210059426
CHECK DATE 07/20/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL
DEPENDENT-

POLICY NO. [redacted]9360 DATE PAID 07-20-10
CLAIM NO. 0809-00062 REF ID. BD310385246

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1901 70	TOTAL DISABILITY	02-25-10	05-25-10	3MO	2000M	6,000.00
	TOTAL DISABILITY	02-25-10	05-25-10	3MO	500M	1,500.00
				TOTAL THIS PAYMENT		7,500.00
				TOTAL PAID TO DATE		60,625.00

PARTIAL PAYMENT

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

PLIC 0389

PLIC 0616

ROA 2340

RMO4231265

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
BD310387907	08/26/10	4210062075	$******5,000.00

VOID SIX (6) MONTHS FROM DATE OF ISSUE

PAY *FIVE THOUSAND DOLLARS & 00/100*

To The Order Of MIKE RUSSELL

2

NON-NEGOTIABLE

Authorized Signature
** Not valid over $10,000 without two signatures **

[redacted]

PENNSYLVANIA LIFE INSURANCE COMPANY

MIKE RUSSELL
SOURCE CODE ACL

CHECK NUMBER 4210062075
CHECK DATE 08/26/10

PENNSYLVANIA LIFE INS CO

INSURED- MIKE RUSSELL POLICY NO. [redacted]9360 DATE PAID 08-26-10
DEPENDENT- CLAIM NO. 0809-00062 REF ID. BD310387907

RIDER	BENEFIT/PROVIDER	FROM	TO	PERIOD	RATE	AMOUNT
1301 70	TOTAL DISABILITY	05-25-10	07-25-10	2MO	2000M	4,000.00
	TOTAL DISABILITY	05-25-10	07-25-10	2MO	500M	1,000.00
				TOTAL THIS PAYMENT		5,000.00
				TOTAL PAID TO DATE		65,625.00

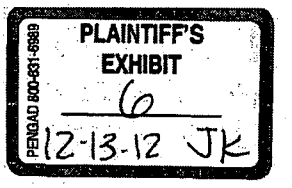
PARTIAL PAYMENT

ADJ 8077 STATE 38 S/C 0044413 M/C 091477

PLIC 0390

PLIC 0617

ROA 2341



POLICY SCHEDULE

INSURED MIKE RUSSELL

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

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

PR-1901

12.90

Russell 0153

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.

/s/ Peter Keuser — Secretary

/s/ 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

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

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.

/s/ Peter Keuser — Secretary

William E. Wehner — President

PR-1946 Ed. 11.96

Russell 0158

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

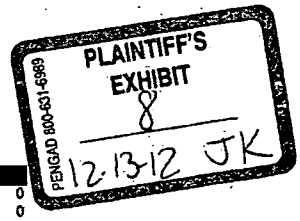
William E. Wehner, President
PENNSYLVANIA LIFE INSURANCE COMPANY

CC: 173416 GILL, RANDOLPH
091476 SC00044425

600 Courtland Street - Suite 400, Orlando, Florida 32804
(800) 275-7366

HOWEL

This is a non-printable statement.



DO NOT MAIL

MIKE C RUSSELL
1469 DOGWOOD RD
WEST COLUMBIA SC 29172-2451

Account Number: [redacted]
Credit Limit: 0
Available Credit: 0
Days in Bill Cycle: 0
Payment Due Date: 08/05/08
Closing Date: 07/11/08

Trans Date	Post Date	Reference Number	Description	Amount
06/10	06/11	2461043HJ03S6A93N	PANTRY EXPRESS #626039 SOUTH CONGARE SC	148.67
06/10	06/12	2407314HKS66EBX0Z	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	50.51
06/10	06/12	2407314HK866LD5HL	WILD HARE SPORTS CAFE COLUMBIA SC	132.33
06/10	06/12	2407314HL866LKPCK	WILD HARE SPORTS CAFE COLUMBIA SC	110.49
06/11	06/12	2407314HL866LKPCK	WILD HARE SPORTS CAFE COLUMBIA SC	85.51
06/11	06/13	2407314HKS66EBX0Z	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	213.22
06/14	06/16	2407314HPS86EF86	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	67.11
06/15	06/16	2407314HR366FAJL8	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	73.22
06/16	06/18	2407314HTS66FGWE4	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	58.06
06/18	06/20	2407314HVS66FX6B0	#3 CAROLINA WINGS & RIBHO WEST COLUMBIA SC	75.00
06/18	06/20	2416405HV801LBP4E	EXXONMOBIL 97385926 COLUMBIA SC	9.64
06/18	06/20	2431605HVFZ2NR7Y7	SHELL OIL 57542561501 WEST COLUMBIA SC	

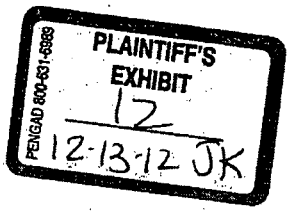
DO NOT MAIL

	COL 1	COL 2	COL 3	COL 4	COL 5	COL 6	COL 7	COL 8
LINE22	1,022.96	0.00	0.00	0.00	0.00	0.00	0.00	0.00
LINE23	0.00	0.00	0.00					
LINE24	0.00	0.000	0.00	0.00	0.00	0.00		

5425 0000 AAA 1 3 7 080711 Page 1 of 1 1 3183 0000 0581 6

LEXINGTON MEDICAL CENTER
Your partner for health and wellness®

FAX



TO: To whom it may concern
Company:
Fax: 8032555927
Phone:

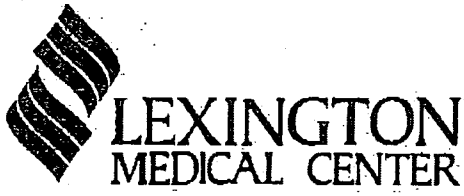
FROM:
Fax: 803-936-8033
Phone: 803-791-2242

NOTES:

Date and time of transmission: Monday, December 03, 2012 12:56:42 PM
Number of pages including cover sheet: 29

THE INFORMATION CONTAINED IN THIS FACSIMILE TRANSMISSION IS PRIVILEGED AND CONFIDENTIAL, INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS RECORD IS STRICTLY PROHIBITED. If you have received this fax in error, please notify the sender immediately by telephone.

PLEASE NOTE: This facsimile may contain **personal health information**, which is protected by federal and state regulation. If you are not the intended recipient, **please notify the Privacy Officer at 803-936-8235, immediately upon receipt**, to arrange for the return of the information.



RISK MANAGEMENT
2720 SUNSET BLVD
WEST COLUMBIA, SC 29169
PHONE NUMBER: (803) 791-2242
FAX NUMBER: (803) 936-8033

FAX COVER SHEET

DATE: December 3, 2012 # OF PAGES INCLUDING COVER SHEET: 29

TO: Kristen E. Horne FAX #: 803.255.5927

COMPANY: Nelson Mullins

MESSAGE: Attached please see information from Tiffni Shealy, Director for Risk Management at Lexington Medical Center in West Columbia, SC.

FROM: Rochelle Iles PHONE: 803-791-2242

Please contact Rochelle Iles at (803) 791-2242
if there is a problem with this transmission.

The information contained in this facsimile message is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this facsimile is strictly prohibited. If you have received this facsimile in error, please immediately notify us by telephone. Thank you.

Dec. 10 Trial

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NOV 16 2012

Nelson Mullins

Nelson Mullins Riley & Scarborough LLP
Attorneys and Counselors at Law
1320 Main Street / 17th Floor / Columbia, SC 29201
Tel: 803.799.2000 Fax: 803.255.5927
www.nelsonmullins.com

Kristen E. Horne
Tel: 803.255.9530
Fax: 803.255.5927
kristen.horne@nelsonmullins.com

November 16, 2012

Via Certified Mail and Email

Tiffni Shealy, Esquire
Lexington Medical Center
2720 Sunset Boulevard
Lexington, South Carolina 29169

RE: Mike Russell v. Randolph Gill and Pennsylvania Life Insurance Company
Civil Action No. 2011-CP-32-04981
Our File No. 15878/01509

Dear Ms. Shealy:

Thank you for your assistance in coordinating the 30(b)(6) deposition of Lexington Medical Center in the above-referenced matter. During the deposition, Ms. Knight referred to additional lab records that she reviewed in preparation for her testimony. I have enclosed a subpoena requesting those records, along with a Records Custodian Affidavit.

Again, thank you for your assistance with this matter. Please do not hesitate to contact me if you require any further information.

Very truly yours,

Kristen Horne

Kristen E. Horne

KEH:dh8
Enclosures

cc: Nick Riley, Esq., *by email only*
Karl Brehmer, Esq., *by email only*

STATE OF SOUTH CAROLINA
ISSUED BY THE COMMON PLEAS COURT IN THE COUNTY OF LEXINGTON

Mike Russell, Plaintiff

v.

Randolph Gill and Pennsylvania Life Insurance Company, Defendants.

SUBPOENA IN A CIVIL CASE

Case Number: 2011-CP-32-4981

TO: **Lexington Medical Center**
2720 Sunset Boulevard
Lexington, SC 29169
Attn: Tiffni Shealy

RECEIVED
NOV 16 2012

☐ YOU ARE COMMANDED to appear in the above named court at the place, and time specified below to testify in the above case.

PLACE OF TESTIMONY	COURTROOM
	DATE AND TIME

☐ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify at the taking of a deposition in the above case.

PLACE OF DEPOSITION	DATE AND TIME

☒ YOU ARE COMMANDED to produce and permit inspection and copying of the following documents or objects in your possession, custody or control at the place, date and time specified below (list documents or objects): **Lab Information System data for any and all lab work done on Mike Russell (DOB: [redacted]; SSN: [redacted], during his hospitalization, including emergency room treatment and admission, from June 18, 2008, to June 20, 2008.**

PLACE **Nelson Mullins Riley & Scarborough; 1320 Main Street, 17th Floor; Columbia, SC 29201**	DATE AND TIME **November 30, 2012**

☐ YOU ARE COMMANDED to permit inspection of the following premises at the date and time specified below.

PREMISES	DATE AND TIME

ANY SUBPOENAED ORGANIZATION NOT A PARTY TO THIS IS HEREBY DIRECTED TO RULE 30(b)(6), SOUTH CAROLINA RULES OF CIVIL PROCEDURE, TO FILE A DESIGNATION WITH THE COURT SPECIFYING ONE OR MORE OFFICERS, DIRECTORS, OR MANAGING AGENTS, OR OTHER PERSONS WHO CONSENT TO TESTIFY ON ITS BEHALF, SHALL SET FORTH, FOR EACH PERSON DESIGNATED, THE MATTERS ON WHICH HE WILL TESTIFY OR PRODUCE DOCUMENTS OR THINGS. THE PERSON SO DESIGNATED TESTIFY AS TO MATTERS KNOWN OR REASONABLY AVAILABLE TO THE ORGANIZATION

I CERTIFY THAT THE SUBPOENA IS ISSUED IN COMPLIANCE WITH RULE 45(c)(1), AND THAT NOTICE AS REQUIRED BY RULE 45(b)(1) HAS BEEN GIVEN TO ALL PARTIES.

Kristen Horne — Attorney for Defendant, Pennsylvania Life Insurance Company — November 16, 2012 — Kristen E. Horne
Attorney/Issuing Officer's Signature — Date — Print Name
Indicate if Attorney for Plaintiff or Defendant
Attorney's Address and Telephone Number:

Nelson Mullins Riley Scarborough L.L.P. 1320 Main Street, 17th Floor, Columbia, SC 29201, (803) 799-2000

Clerk of Court/Issuing Officer's Signature — Date — Print Name
Indicate if Attorney for Plaintiff or Defendant
Pro Se Litigant's Name, Address and Telephone Number:

SCCA 254 (05/2011)

(See Rule 45, South Carolina Rules of Civil Procedure, Parts (c) & (d) on next page)

SUB_Lex Med Ctr_0004

PROOF OF SERVICE

SERVED	DATE	FEES AND MILEAGE TENDERED TO WITNESS
	PLACE	☐YES ☐NO AMOUNT $
SERVED ON		MANNER OF SERVICE
SERVED BY		TITLE

DECLARATION OF SERVER

I certify that the foregoing information contained in the Proof of Service is true and correct.

Executed on_____

SIGNATURE OF SERVER

ADDRESS OF SERVER

Rule 45, South Carolina Rules of Civil Procedures, Parts (c) and (d):

(c) Protection of Persons Subject to Subpoenas.

(1) A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing undue burden or expense on a person subject to that subpoena. The court on behalf of which the subpoena was issued shall enforce this duty and impose upon the party or attorney in breach of this duty an appropriate sanction, which may include, but is not limited to, lost earnings and a reasonable attorney's fee.

(2) (A) A person commanded to produce and permit inspection and copying of designated books, papers, documents or tangible things, or inspection of premises need not appear in person at the place of production or inspection unless commanded to appear for deposition, hearing or trial. A party or an attorney responsible for the issuance and service of a subpoena for production of books, papers and documents without a deposition shall provide to another party copies of documents so produced upon written request. The party requesting copies shall pay the reasonable costs of reproduction.

(B) Subject to paragraph (d) (2) of this rule, a person commanded to produce and permit inspection and copying may, within 14 days after service of the subpoena or before the time specified for compliance if such time is less than 14 days after service, serve upon the party or attorney designated in the subpoena written objection to inspection or copying of any or all of the designated materials or of the premises. If objection is made, the party serving the subpoena shall not be entitled to inspect and copy the materials or inspect the premises except pursuant to an order of the court by which the subpoena was issued. If objection has been made, the party serving the subpoena may, upon notice to the person commanded to produce, move at any time in the court that issued the subpoena for an order to compel the production. Such an order to compel production shall protect any person who is not a party or an officer of a party from significant expense resulting from the inspection and copying commanded.

(3) (A) On timely motion, the court by which a subpoena was issued, or regarding a subpoena commanding appearance at a deposition, or production or inspection directed to a non-party, the court in the county where the non-party resides, is employed or regularly transacts business in person, shall quash or modify the subpoena if it:

i. fails to allow reasonable time for compliance; or

ii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to travel more than 50 miles from the county where that person resides, is employed or regularly transacts business in person, except that, subject to the provisions of clause (c)(3)(B)(iii) of this rule, such a person may in order to attend trial be commanded to travel from any such place within the state in which the trial is held; or

iii. requires disclosure of privileged or otherwise protected matter and no exception or waiver applies; or

iv. subjects a person to undue burden.

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NOV 16 2012

(B) If a subpoena:

i. requires disclosure of a trade secret or other confidential research, development, or commercial information, or

ii. requires disclosure of an unretained expert's opinion or information not describing specific events or occurrences in dispute and resulting from the expert's study made not at the request of any party, or

iii. requires a person who is not a party nor an officer, director or managing agent of a party, nor a general partner of a partnership that is a party, to incur substantial expense to travel from the county where that person resides, is employed or regularly transacts business in person,

the court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena or, if the party in whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship and assures that the person to whom the subpoena is addressed will be reasonably compensated, the court may order appearance or production only upon specified conditions.

(d) Duties in Responding to Subpoena.

(1) A person responding to a subpoena to produce documents shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the demand.

(2) When information subject to a subpoena is withheld on a claim that it is privileged or subject to protection as trial preparation materials, the claim shall be made expressly and shall be supported by a description of the nature of the documents, communications, or things not produced that is sufficient to enable the demanding party to contest the claim.

STATE OF SOUTH CAROLINA)
) RECORDS CUSTODIAN AFFIDAVIT
COUNTY OF _____)

PERSONALLY appeared before me, _____, who, being duly sworn, deposes and says:

1. I am the Records Custodian for _____.

2. I have reviewed the records in this office relative to **Mike Russell.**

3. The attached documents are all of the records of this office meeting the following description:

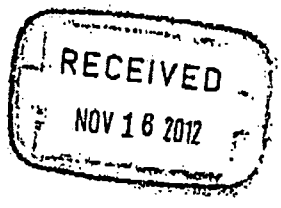
   Lab Information System data for any and all lab work done on Mike Russell (DOB: [redacted]; SSN: [redacted]), during his hospitalization, including emergency room treatment and admission, from June 18, 2008, to June 20, 2008.

4. All of the attached documents are copies of records which are kept in the ordinary course of business by this office.

_____

SWORN TO AND SUBSCRIBED before me
This ____ day of _____, 2012.

_____
Notary Public for South Carolina
My Commission Expires: _____



Lexington Medical 12/3/2012 12:58:57 PM PAGE 7/029 Fax Server

SUB_Lex Med Ctr_0007

ROA 2358

K0001529871 RUSSELL,MICHAEL C

Tech Code Inquiry

TECH CODE: 886

Jill Burroughs

Wednesday, 0, 2012 01:46 PM

Time of report: 11/26/2012 1041

RUSSELL,MICHAEL C [redacted]
DOB: [redacted] (40Y) Sex: M
Soc Sec #: [redacted]

Hospital ID: LXC
Location: TRI
Att phys 1: Suarez, Randall, S, MD (C)
Att phys 2:

W2544 [redacted] Collect D/T: 06/18/2008 2300 Receive D/T: 06/18/2008 2326
Order account #: [redacted] Order location: HEDZ2

Order physician: Hall, Rick,MD

COMPREHENSIVE METABO						
GLUCOSE	*	113	[70-100]	mg/dL	(4-A)	STAT
SODIUM		142	[135-145]	MEQ/L	(4-A)	STAT
POTASSIUM		4.6	[3.5-5.5]	MEQ/L	(873)	STAT
		SLT HEMOLYSIS				
CHLORIDE	*	110	[98-107]	MEQ/L	(4-A)	STAT
CO2	*	17	[23.0-31.0]	MEQ/L	(4-A)	STAT
ANION GAP		15	[7-16]	MEQ/L	(4-A)	STAT
BUN		12	[5-25]	MG/DL	(4-A)	STAT
CREATININE		0.93	[0.65-1.25]	MG/DL	(4-A)	STAT
		Please note new reference range effective 05/08/08 @1200.				
CALCIUM	*	8.0	[8.7-10.2]	MG/DL	(4-A)	STAT
BILIRUBIN,TOTAL		0.5	[0-1.0]	MG/DL	(4-A)	STAT
BILIRUBIN, DIRECT		0.3	[0-0.4]	MG/DL	(4-A)	STAT
TOTAL PROTEIN		6.9	[6.3-8.2]	GM/DL	(4-A)	STAT
ALBUMIN		3.9	[3.5-5.0]	GM/DL	(4-A)	STAT
AST (SGOT)	*	101	[14-50]	U/L	(4-A)	STAT
ALT (SGPT)		63	[21-72]	U/L	(4-A)	STAT
ALK PHOSPHATASE		118	[50-136]	U/L	(4-A)	STAT
GGTP	*	195	[8-78]	U/L	(4-A)	STAT
eGFR		>60	[>60]	mL/min/1.73 sqm	(4-A)	STAT
		(Multiply result X 1.2 if Afr. Am.)				
ALCOHOL	*	0.232	[<0.01]	%	(4-A)	STAT
<<XTRA GREEN TUBE>>		SPECIMEN ON HOLD IN LAB FOR FUTURE TESTING.			(839)	
CBC HEMOGRAM						
WBC	*	14.7	[4.0-11.0]	K/ul	(4-A)	STAT
RBC	*	4.31	[4.60-6.10]	M/ul	(4-A)	STAT
HGB		13.8	[13.5-18.0]	gm/dl	(4-A)	STAT
HCT	*	39.3	[41.0-53.0]	%	(4-A)	STAT
MCV		91.2	[80.0-98.0]	fl	(4-A)	STAT
MCHC		35.0	[32.0-36.0]	gm/dl	(4-A)	STAT
RDW		13.0	[11.5-14.5]	%	(4-A)	STAT
PLT		266	[130-400]	K/ul	(4-A)	STAT
<<CONDITIONAL>>		<<DO NOT REPORT>>			(4-A)	STAT
DIFFERENTIAL						
% LYMPHOCYTES		18	[17-44]	%	(4-A)	STAT
% NEUTROPHILS	*	75	[43-72]	%	(4-A)	STAT
% MONOCYTES		6	[0-10]	%	(4-A)	STAT
% EOSINOPHILS		1	[0-5]	%	(4-A)	STAT
% BASOPHILS		0	[0-3]	%	(4-A)	STAT
ABS NEUTROPHILS	*	10.90	[1.7-8.0]	K/ul	(4-A)	STAT
ABS LYMPHOCYTES		2.70	[0.7-5.0]	K/ul	(4-A)	STAT
ABS MONOCYTES		0.90	[0.0-1.1]	K/ul	(4-A)	STAT
ABS EOSINOPHILS		0.20	[0.0-0.6]	K/ul	(4-A)	STAT
ABS BASOPHILS		0.00	[0.0-0.2]	K/ul	(4-A)	STAT
% NRBC		0	[0]	%	(4-A)	STAT
ABS NRBC		0.0	[0.0]	K/uL	(4-A)	STAT
PROTHROMBIN TIME						
PROTHROMBIN TIME	*	12.1	[12.3-14.9]	Sec	(711)	STAT
INR,PROTHROMBIN TIME		0.9	[0.9-1.1]		(711)	STAT
		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				
PTT	*	20.7	[28.0-35.6]	SEC	(711)	STAT

Therapeutic Range: [55-90] Sec

W2560 Collect D/T: 06/18/2008 2300 Receive D/T: 06/18/2008 2335
Order account #: [redacted] Order location: HEDZ2
Order physician: Hall, Rick,MD

<<EXTRA BB TUBE FOR HO>>	SEE BLOOD BANK	(839)	

H349 Collect D/T: 06/18/2008 2300 Receive D/T: 06/19/2008 0042
Order account #: [redacted] Order location: HEDZ2
Order physician: Hall, Rick,MD
TYPE SCREEN AND HOLD

<<BLOOD COMPONENT TYPE>>	RED CELL GROUP		STAT
<<UNITS ORDERED>>	<<DO NOT REPORT>>		STAT
ABO/RH(D)	O POSITIVE	(854)	STAT
ANTIBODY SCREEN	NEGATIVE	(854)	STAT
<<CROSSMATCH EXPIRATIO>>	06/21/2008	(854)	STAT
<<ARM BAND NUMBER>>	HIDE		STAT
NOTE:	TYPE AND SCREEN ONLY		STAT
<<HISTORY CHECK>>	CHECK DONE	(854)	STAT

*** END OF REPORT ***

[redacted].TXT

FUNCTION: STT

T R N S A V E F I L E S E A R C H

Start date: 06/18/2008
End date: 06/19/2008

Priority: 0,1,2,3

Key 1: "W2544"
Key 2: "H349"

Trnsave device#: 47

Enter BPI value : 6250

TRNSAVE Tape Mount Requested - please wait...

TRNSAVE Tape Mounted - <cr> to continue, * to abort: Continue

BEGIN SEARCH FOR ~1\TRNSAVE TAPE\06/18/2008 - 06/19/2008

Scanning past 06/01/2008 (11841)

Scanning past 06/02/2008 (11842)

Scanning past 06/03/2008 (11843)

Scanning past 06/04/2008 (11844)

Scanning past 06/05/2008 (11845)

Scanning past 06/06/2008 (11846)

Scanning past 06/07/2008 (11847)

Scanning past 06/08/2008 (11848)

Scanning past 06/09/2008 (11849)

Scanning past 06/10/2008 (11850)

Scanning past 06/11/2008 (11851)

Scanning past 06/12/2008 (11852)

Scanning past 06/13/2008 (11853)

Scanning past 06/14/2008 (11854)

Scanning past 06/15/2008 (11855)

Scanning past 06/16/2008 (11856)

Scanning past 06/17/2008 (11857)

---------- SEARCH 06/18/2008 (11858) ----------

Queue: 0

06/18/200822:48:34 0 88677 5!!0#82114C#/dev/null:80792#LXCI6J2##M001529871:1|
11377834#(GOP5) OE INTERFACE#0#11858#\N\\123P1055#
186L39301\332;1\1,M001529871,1,EP,9,1\H00034689372
\ER\HEDZ2;1\06182008,2248\HEDZ2;1#0\\\\\\\\\\\\\7
88677/W2544
\3\!11858,2253#!11858,2253###\\\\0\\\1\\\\\\\\\ER
88677/W2544,1
O\A\CBCD#P\LAB20080618:4497-0##CBCD\1#S
88677/W2544,1,CBCH
\\H\9#9\\\\186C119644\\\CBCD\\\\\\186C119645
88677/W2544,1,DFFS
\\H\1#1\\\\186C119646\\\CBCD\\\\\\186C119647

[redacted].TXT

```
06/18/200822:48:36 0 88682    S!!0#82116C#/dev/null:80792#LXCI6J2##M001529871;1|
                              11377835#(GOP5) OE INTERFACE#0#11858#\C\\123P1055#
                              186L39301\332;1\1,M001529871,1,EP,9,1\H00034689372
                              \ER\HEDZ2;1\06182008,2248\HEDZ2;1#0\\\\\\\\\\\\\7
                         88682/W2544
                              \\\\\\0\\\\\\\\\\\ER

Date      Time     Q Trn#     Data                                          ORDER
--------  -------- - ----     ----
                         88682/W2544,1
                              O\A\PTPTT#P\LAB20080618:4498-0##PTPTT\1#S
                         88682/W2544,1,PTM
                              \\HS\2#2\\\\186C119648\\\PTPTT\\\\\\186C119649
                         88682/W2544,1,PTT
                              \\HS\1#1\\\\\186C119650\\\PTPTT\\\\\\186C119651

06/18/200822:48:41 0 88685    S!!0#82121C#/dev/null:80792#LXCI6J2##M001529871;1|
                              11377836#(GOP5) OE INTERFACE#0#11858#\C\\123P1055#
                              186L39301\332;1\1,M001529871,1,EP,9,1\H00034689372
                              \ER\HEDZ2;1\06182008,2248\HEDZ2;1#0\\\\\\\\\\\\\7
                         88685/W2544
                              \\\\\\0\\\\\\\\\\\ER
                         88685/W2544,1
                              O\A\CMET#B\LAB20080618:4499-0##CMET\1#S
                         88685/W2544,1,CMET
                              \\C\18#18\\\\186C119652\\\\\\\\\186C119653

Date      Time     Q Trn#     Data
--------  -------- - ----     ----

06/18/200822:48:46 0 88688    S!!0#82126C#/dev/null:80792#LXCI6J2##M001529871;1|
                              11377838#(GOP5) OE INTERFACE#0#11858#\C\\123P1055#
                              186L39301\332;1\1,M001529871,1,EP,9,1\H00034689372
                              \ER\HEDZ2;1\06182008,2248\HEDZ2;1#0\\\\\\\\\\\\\7
                         88688/W2544
                              \\\\\\0\\\\\\\\\\\ER
                         88688/W2544,1
                              O\A\ETOH#T\LAB20080618:4500-0##ETOH\1#S
                         88688/W2544,1,ETOH
                              \\C\1#1\\\\186C119654\\\\\\\\\186C119655

06/18/200822:49:34 0 88694    12\82174\/dev/null:80792(GIP2)\LXCI6J2#ER#0#3###M0
                              01529871;1|11377844\M001529871;1\\HEDZ2;1#1,M00152
                              9871,1,EP,9,1#HEDZ2;1##HEDZ2;1\\RUSSELL#MICHAEL C\
                              W2544\11858,2253\\07071972#M\\\CBCD#CMET#ETOH#PTPT
                              T#\

06/18/200823:34:31 0 89644    S!!0#84871C#LWF MDFY|#117790#839#M001529871;1|1137
                              8300#CLVS#0#11858\C\\123P1055#186L39301\332;1\1,M0
                              01529871,1,EP,9,1\\T

Date      Time     Q Trn#     Data
--------  -------- - ----     ----                                          Receive
                         89644/W2544
                              \7\839!11858,2253#886!11858,2300#839!11858,2326###
                              \\\\\VP,1
                         89644/W2544,1
                              O\A\XGRN#T\E886825-0
                         89644/W2544,1,XGRN
                              \\C\1#1
                         89644/W2544,2
                              O\C\CBCD#P\\1#S\S-;NA
                         89644/W2544,2,CBCH
                              \\\\\\\\\\\\\\\186C119799
                         89644/W2544,2,DFFS
                              \\\\\\\\\\\\\\\186C119800
                         89644/W2544,3
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                         89644/W2544,3,CMET
                              \\\\\\\\\\\\\\\186C119801
                         89644/W2544,4
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[redacted].TXT
O\C\ETOH#T\\1#S\S-;NA
89644/W2544,4,ETOH
\\\\\\\\\\\\\\\\186C119802

Date	Time	Q	Trn#	Data
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				\\\\\\\\\\\\\\\\186C119803
			89644/W2544,5,PTT	
				\\\\\\\\\\\\\\\\186C119804
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06/18/200823:35:05		0	89657	34\84905\Q54\Q54\\^ONL(0,"ACTI","LL","ACTIDYN",896 9,1)\W2544\
06/18/200823:35:05		0	89663	34\84905\Q54\Q54\\^ONL(0,"ACTL","LL","ACTLDYN",488 8,1)\W2544\
06/18/200823:35:05		0	89669	34\84905\Q54\Q54\\^ONL(0,"COU1","LL","COU1DYN",669 7,1)\W2544\
06/18/200823:35:05		0	89675	34\84905\Q54\Q54\\^ONL(0,"COU2","LL","COU2DYN",672 0,1)\W2544\
Date	Time	Q	Trn#	Data
06/18/200823:35:05		0	89681	34\84905\Q54\Q54\\^ONL(0,"E250","LL","E250DYN",146 0,1)\W2544\
06/18/200823:35:05		0	89687	34\84905\Q54\Q54\\^ONL(0,"E250I","LL","E250IDYN",4 322,1)\W2544\
06/18/200823:35:05		0	89694	34\84905\Q54\Q54\\^ONL(0,"FUS1","LL","FUS1DYN",704 ,1)\W2544\
06/18/200823:35:05		0	89701	34\84905\Q54\Q54\\^ONL(0,"FUS2","LL","FUS2DYN",761 2,1)\W2544\
06/18/200823:35:05		0	89707	34\84905\Q54\Q54\\^ONL(0,"STA1","LL","STA1DYN",340 6,1)\W2544\
06/18/200823:35:05		0	89713	34\84905\Q54\Q54\\^ONL(0,"STA2","LL","STA2DYN",317 6,1)\W2544\
06/18/200823:44:06		0	90005	50F!!0#85446#^IX07A!#COU1###IXW0P##11858\COU1#254# 254\0\W2544\
Date	Time	Q	Trn#	Data
			90005/254W2544#W2544#R#\254\\P##\\\\\	
			90005/254,2	
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			90005/254,2,I	
			90005/254,2,I,1	
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			90005/254,2,I,1,1	
				N\14.7
			90005/254,2,I,1,2	
				T\
			90005/254,2,I,1,2,1	
				H
			90005/254,2,P	
				\2#*![4.0-11.0] K/ul#*#H\\\\WBC\\\\\\
			90005/254,2,P,1	
				0
			90005/254,2,P,1,1	
				N\14.7

Result

SUB_Lex Med Ctr_0012

[redacted].TXT

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                    90005/254,2,P,1,2
                              T\

Date        Time      Q Trn#      Data
--------    --------  - ----      ----
                    90005/254,2,P,1,2,1
                              H
                    90005/254,3
                              O\
                    90005/254,3,I

                    90005/254,3,I,1
                              O
                    90005/254,3,I,1,1
                              N\4.31
                    90005/254,3,I,1,2
                              T\
                    90005/254,3,I,1,2,1
                              L
                    90005/254,3,P
                              \1#*![4.60-6.10] M/ul#*#L\\\\\RBC\\\\\\
                    90005/254,3,P,1
                              O
                    90005/254,3,P,1,1
                              N\4.31

Date        Time      Q Trn#      Data
--------    --------  - ----      ----
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                              T\
                    90005/254,3,P,1,2,1
                              L
                    90005/254,4
                              O\
                    90005/254,4,I

                    90005/254,4,I,1
                              O
                    90005/254,4,I,1,1
                              N\13.8
                    90005/254,4,P
                              \###\\\\HGB\\\\\\
                    90005/254,4,P,1
                              O
                    90005/254,4,P,1,1
                              N\13.8
                    90005/254,5
                              O\

Date        Time      Q Trn#      Data
--------    --------  - ----      ----
                    90005/254,5,I

                    90005/254,5,I,1
                              O
                    90005/254,5,I,1,1
                              N\39.3
                    90005/254,5,I,1,2
                              T\
                    90005/254,5,I,1,2,1
                              L
                    90005/254,5,P
                              \1#*![41.0-53.0] %#*#L\\\\HCT\\\\\\
                    90005/254,5,P,1
                              O
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                              T\
                    90005/254,5,P,1,2,1
                              L

Date        Time      Q Trn#      Data
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[redacted].TXT

Date	Time	Q	Trn#	Data
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			90005/254,6,I,1	
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			90005/254,6,I,1,1	
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			90005/254,6,P	
				\###\\\\MCV\\\\\\
			90005/254,6,P,1	
				0
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				N\91.2
			90005/254,7,I	
			90005/254,7,I,1	
				0
			90005/254,7,I,1,1	
				N\31.9

Date	Time	Q	Trn#	Data
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			90005/254,8,I,1	
				0
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				\###\\\\MCHC\\\\\\
			90005/254,8,P,1	
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				N\35.0
			90005/254,9	
				0\
			90005/254,9,I	
			90005/254,9,I,1	
				0

Date	Time	Q	Trn#	Data
			90005/254,9,I,1,1	
				N\13.0
			90005/254,9,P	
				\###\\\\RDW\\\\\\
			90005/254,9,P,1	
				0
			90005/254,9,P,1,1	
				N\13.0
			90005/254,10	
				0\
			90005/254,10,I	
			90005/254,10,I,1	
				0
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				N\266
			90005/254,10,P	
				\###\\\\PLT\\\\\\
			90005/254,10,P,1	
				0

Date	Time	Q	Trn#	Data
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			90005/254,11,I	

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                T\
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                L
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                0\
90005/254,12,I

90005/254,12,I,1
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90005/254,12,I,1,1
                N\74
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Date	Time	Q	Trn#	Data

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                T\
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                H
90005/254,12,P
                \2#*![43-72] %#*#H\8\\\NEUT\\\\\\
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90005/254,12,P,1,1
                N\75
90005/254,12,P,1,2
                T\
90005/254,12,P,1,2,1
                H
90005/254,13
                0\
90005/254,13,I

90005/254,13,I,1
                0
```

Date	Time	Q	Trn#	Data

```
90005/254,13,I,1,1
                N\18
90005/254,13,P
                \###\\\\LYMP\\\\\\
90005/254,13,P,1
                0
90005/254,13,P,1,1
                N\18
90005/254,14
                0\
90005/254,14,I

90005/254,14,I,1
                0
90005/254,14,I,1,1
                N\6
90005/254,14,P
                \###\8\\\MONO\\\\\\
90005/254,14,P,1
                0
```

Date	Time	Q	Trn#	Data

```
90005/254,14,P,1,1
                N\6
90005/254,15
                0\
90005/254,15,I

90005/254,15,I,1
```

[redacted].TXT

```
                    0
90005/254,15,I,1,1
                    N\1
90005/254,15,P
                    \###\8\\\EOS\\\\\\
90005/254,15,P,1
                    0
90005/254,15,P,1,1
                    N\1
90005/254,16
                    0\
90005/254,16,I

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,16,I,1
                    0
90005/254,16,I,1,1
                    N\0
90005/254,16,P
                    \###\8\\\BA\\\\\\
90005/254,16,P,1
                    0
90005/254,16,P,1,1
                    N\0
90005/254,17
                    0\
90005/254,17,I

90005/254,17,I,1
                    0
90005/254,17,I,1,1
                    N\10.90
90005/254,17,I,1,2
                    T\

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,17,I,1,2,1
                    H
90005/254,17,P
                    \2#*![1.7-8.0] K/ul#*#H\8\\\ANEUT\\\\\\
90005/254,17,P,1
                    0
90005/254,17,P,1,1
                    N\10.90
90005/254,17,P,1,2
                    T\
90005/254,17,P,1,2,1
                    H
90005/254,18
                    0\
90005/254,18,I

90005/254,18,I,1
                    0
90005/254,18,I,1,1
                    N\2.70

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,18,P
                    \###\8\\\ALYMP\\\\\\
90005/254,18,P,1
                    0
90005/254,18,P,1,1
                    N\2.70
90005/254,19
                    0\
90005/254,19,I

90005/254,19,I,1
```

[redacted].TXT

```
                    0
90005/254,19,I,1,1
                    N\0.90
90005/254,19,P
                    \###\8\\\AMONO\\\\\\
90005/254,19,P,1
                    0
90005/254,19,P,1,1
                    N\0.90

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,20
                    0\
90005/254,20,I

90005/254,20,I,1
                    0
90005/254,20,I,1,1
                    N\0.20
90005/254,20,P
                    \###\8\\\AEOS\\\\\\
90005/254,20,P,1
                    0
90005/254,20,P,1,1
                    N\0.20
90005/254,21
                    0\
90005/254,21,I

90005/254,21,I,1
                    0

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,21,I,1,1
                    N\0.00
90005/254,21,P
                    \###\8\\\ABA\\\\\\
90005/254,21,P,1
                    0
90005/254,21,P,1,1
                    N\0.00
90005/254,30
                    0\
90005/254,30,I

90005/254,30,I,1
                    0
90005/254,30,I,1,1
                    C\HIDE
90005/254,30,P
                    3\###\\\\CND\\\\\\
90005/254,30,P,1
                    0

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
90005/254,30,P,1,1
                    C\HIDE
90005/254,31
                    0\
90005/254,31,I

90005/254,31,I,1
                    0
90005/254,31,I,1,1
                    N\0
90005/254,31,P
                    \###\8\\\NRBCA\\\\\\
90005/254,31,P,1
                    0
90005/254,31,P,1,1
```

[redacted].TXT

```
                    N\0
                90005/254,32
                    0\
                90005/254,32,I

Date        Time        Q Trn#      Data
--------    --------    - ----      ----
                90005/254,32,I,1
                    0
                90005/254,32,I,1,1
                    N\0.0
                90005/254,32,P
                    \###\8\\\ANRBCA\\\\\\
                90005/254,32,P,1
                    0
                90005/254,32,P,1,1
                    N\0.0
06/18/200823:49:42 0 90174  50F!!0#85782#^IX07A!#STA1###IXW0P##11858\STA1#872#
                    872\0\W2544\
                90174/872W2544###\872\\P#1#474\\\\\
                90174/872,2
                    0\
                90174/872,2,I

                90174/872,2,I,1
                    0
Date        Time        Q Trn#      Data
--------    --------    - ----      ----
                90174/872,2,I,1,1
                    N\12.1
                90174/872,2,P
                    \1#*![12.3-14.9] Sec#*#L\\\\PT\\\\\\
                90174/872,2,P,1
                    0
                90174/872,2,P,1,1
                    N\12.1
                90174/872,3
                    0\
                90174/872,3,I

                90174/872,3,I,1
                    0
                90174/872,3,I,1,1
                    N\0.9
                90174/872,3,P
                    \###\\\\PTINR\\INRC\\\\
                90174/872,3,P,1
                    0
Date        Time        Q Trn#      Data
--------    --------    - ----      ----
                90174/872,3,P,1,1
                    N\0.9
                90174/872,4
                    0\
                90174/872,4,P
                    \\\\760
06/18/200823:50:14 0 90186  50F!!0#85814#^IX07A!#STA1###IXW0P##11858\STA1#872#
                    872\0\W2544\
                90186/872W2544###\872\\P#1#474\\\\\
                90186/872,2
                    0\
                90186/872,2,I

                90186/872,2,I,1
                    0
                90186/872,2,I,1,1
                    N\12.1
                90186/872,2,P
```

[redacted].TXT

```
                                \1#*![12.3-14.9] Sec#*#L\\\\PT\\\\\\

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    90186/872,2,P,1
                              0
                    90186/872,2,P,1,1
                              N\12.1
                    90186/872,3
                              0\
                    90186/872,3,I

                    90186/872,3,I,1
                              0
                    90186/872,3,I,1,1
                              N\0.9
                    90186/872,3,P
                              \###\\\\PTINR\\INRC\\\\
                    90186/872,3,P,1
                              0
                    90186/872,3,P,1,1
                              N\0.9
                    90186/872,4
                              0\

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    90186/872,4,I

                    90186/872,4,I,1
                              0
                    90186/872,4,I,1,1
                              N\20.7
                    90186/872,4,P
                              \1#*![28.0-35.6] SEC#*#L\\\467\PTT\\HEPE\\\\
                    90186/872,4,P,1
                              0
                    90186/872,4,P,1,1
                              N\20.7

06/18/200823:56:39 0 90312    50F!!O#86199#SMR!#107798###IXWOP##11858\STA1#872#8
                              72\1\W2544\
                    90312/872W2544#W2544##\872\\P#1#474\\\\\

                              Queue: 1

06/18/200823:34:31 1 16588    7!B!O#84871C#LWF MDFY#117790#839##CLVS##11858\T\18
                              6L39301\W2544\XGRN\\2\\\\\\

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    16588/XGRN
                              1\\\65\T\\\\\\\\\\\\
                    16588/XGRN,1

                    16588/XGRN,1,1
                              C\SEEC

06/18/200823:56:39 1 16622    7!B!O#86199C#SMR#107798#711##OEM##11858\ER\186L393
                              01\W2544\PTM\\3\\\0\\STA1\
                    16622/PT \STA1\1\1\ER\\\\\\\\\\\\\
                    16622/PT,1

                    16622/PT,1,1
                              N\12.1
                    16622/PTINR
                              \STA1\\1\ER\\\\\\\\\\\\
                    16622/PTINR,1

                    16622/PTINR,1,1
                              N\0.9

Date      Time     Q Trn#     Data
```

[redacted].TXT

```
Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    16622/PTINR,1,2
                             C\INRC

06/18/200823:56:39 1 16623    7!B!O#86199C#SMR#107798#711#STA1,W2544|11378542|ST
                             A1,872|11378541#OEM##11858\ER\186L39301\W2544\PTT\
                             \3\\\O\\STA1\
                    16623/PTT\STA1\1\1\ER\\\\\\\\\\\\\
                    16623/PTT,1

                    16623/PTT,1,1
                             N\20.7
                    16623/PTT,1,2
                             C\HEPE

                             Queue: 2

06/18/200823:34:31 2 11479    71\84871C\LWF MDFY\117790#T\\886\11858,2\9999\9999
                             !!VP!1\\\W2544

06/18/200823:44:06 2 11496    7!B!O#85446C#JDC#IX62234#4-A##IXPRO##11858\R\186L3
                             9301\W2544\CBCH\\3\\\\O\COU1\

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    11496/CND3\COU1\\\1\R\\\\\\\\\\\\\
                    11496/HCT\COU1\1\1\R\\\\\\\\\\\\\
                    11496/HCT,1

                    11496/HCT,1,1
                             N\39.3
                    11496/HGB\COU1\\\1\R\\\\\\\\\\\\\
                    11496/HGB,1

                    11496/HGB,1,1
                             N\13.8
                    11496/MCHC
                             \COU1\\\1\R\\\\\\\\\\\\\
                    11496/MCHC,1

                    11496/MCHC,1,1
                             N\35.0
                    11496/MCV\COU1\\\1\R\\\\\\\\\\\\\
                    11496/MCV,1


Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    11496/MCV,1,1
                             N\91.2
                    11496/PLT\COU1\\\1\R\\\\\\\\\\\\\
                    11496/PLT,1

                    11496/PLT,1,1
                             N\266
                    11496/RBC\COU1\1\1\R\\\\\\\\\\\\\
                    11496/RBC,1

                    11496/RBC,1,1
                             N\4.31
                    11496/RDW\COU1\\1\R\\\\\\\\\\\\\
                    11496/RDW,1

                    11496/RDW,1,1
                             N\13.0
                    11496/WBC\COU1\2\1\R\\\\\\\\\\\\\
                    11496/WBC,1


Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    11496/WBC,1,1
                             N\14.7
```

```
06/18/200823:44:06 2 11497    7|B|O#85446C#JDC#IX62234#4-A#COU1,W2544|11378418#I
                              XPRO##11858\R\186L39301\W2544\DFFS\\3\\\\O\COU1\
                      11497/ABA\COU1\\9\R\\10\\\\\\\\\\
                      11497/ABA,1

                      11497/ABA,1,1
                              N\0.00
                      11497/AEOS
                              \COU1\\9\R\\9\\\\\\\\\\
                      11497/AEOS,1

                      11497/AEOS,1,1
                              N\0.20
                      11497/ALYMP
                              \COU1\\9\R\\7\\\\\\\\\\
                      11497/ALYMP,1

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                      11497/ALYMP,1,1
                              N\2.70
                      11497/AMONO
                              \COU1\\9\R\\8\\\\\\\\\\
                      11497/AMONO,1

                      11497/AMONO,1,1
                              N\0.90
                      11497/ANEUT
                              \COU1\2\9\R\\6\\\\\\\\\\
                      11497/ANEUT,1

                      11497/ANEUT,1,1
                              N\10.90
                      11497/ANRBCA
                              \COU1\\9\R\\12\\\\\\\\\\
                      11497/ANRBCA,1

                      11497/ANRBCA,1,1
                              N\0.0

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                      11497/BA \COU1\\9\R\\5\\\\\\\\\\
                      11497/BA,1

                      11497/BA,1,1
                              N\0
                      11497/EOS\COU1\\9\R\\4\\\\\\\\\\
                      11497/EOS,1

                      11497/EOS,1,1
                              N\1
                      11497/LYMP
                              \COU1\\1\R\\\\\\\\\\\\
                      11497/LYMP,1

                      11497/LYMP,1,1
                              N\18
                      11497/MONO
                              \COU1\\9\R\\3\\\\\\\\\\
                      11497/MONO,1

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                      11497/MONO,1,1
                              N\6
                      11497/NEUT
                              \COU1\2\9\R\\2\\\\\\\\\\
                      11497/NEUT,1
```

[redacted].TXT

```
                    11497/NEUT,1,1
                              N\75
                    11497/NRBCA
                              \COU1\\9\R\\11\\\\\\\\\\
                    11497/NRBCA,1

                    11497/NRBCA,1,1
                              N\0

06/18/200823:46:03 2 11502    101\85563\SMR\######COU1,W2544!11378499|COU1,254|1
                              1378498|\\\\\\

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06/18/200823:35:05 3 12029    50E\84905\Q54\Q54\\11858,W2544,84360#

--------------------------- SEARCH 06/19/2008 (11859) ---------------------------

                              Queue: 0

Date      Time     Q Trn#     Data
--------  -------- - ----     ----

06/19/200800:02:32 0 43       50F!!0#152#^IX07A!#FUS1###IXW0P##11859\FUS1#382#38
                              2\0\W2544\
                    43/382    W2544#W2544#R#\382\\P##\\\\\
                    43/382,2 0\
                    43/382,2,I

                    43/382,2,I,1
                              0
                    43/382,2,I,1,1
                              N\113
                    43/382,2,P
                              \2#*![70-100] mg/dL#*#H\\\\GLU\\\\\\
                    43/382,2,P,1
                              0
                    43/382,2,P,1,1
                              N\113
                    43/382,3 0\
                    43/382,3,I

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    43/382,3,I,1
                              0
                    43/382,3,I,1,1
                              N\142
                    43/382,3,P
                              \###\\\\NA\\\\\\
                    43/382,3,P,1
                              0
                    43/382,3,P,1,1
                              N\142
                    43/382,5 0\
                    43/382,5,I

                    43/382,5,I,1
                              0
                    43/382,5,I,1,1
                              N\4.6
                    43/382,5,P
                              \###\\\\K\\\\\\
                    43/382,5,P,1
                              0

Date      Time     Q Trn#     Data
--------  -------- - ----     ----
                    43/382,5,P,1,1
                              N\4.6
                    43/382,7 0\
```
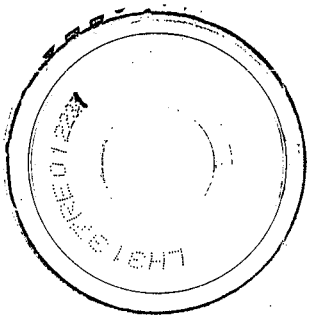

[redacted].TXT

```
                    43/382,7,I
                    43/382,7,I,1
                              0
                    43/382,7,I,1,1
                              N\110
                    43/382,7,P
                              \2#*![98-107] MEQ/L#*#H\\\\CL\\\\\\
                    43/382,7,P,1
                              0
                    43/382,7,P,1,1
                              N\110
                    43/382,8 0\
                    43/382,8,I
                    43/382,8,I,1
                              0

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,8,I,1,1
                              N\17
                    43/382,8,P
                              \1#*![23.0-31.0] MEQ/L#*#L\\\\CO2\\\\\\
                    43/382,8,P,1
                              0
                    43/382,8,P,1,1
                              N\17
                    43/382,9 0\
                    43/382,9,I
                    43/382,9,I,1
                              0
                    43/382,9,I,1,1
                              N\15
                    43/382,9,P
                              \###\\\\AGAP\\\\\\
                    43/382,9,P,1
                              0
                    43/382,9,P,1,1
                              N\15

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,100\
                    43/382,10,I
                    43/382,10,I,1
                              0
                    43/382,10,I,1,1
                              N\12
                    43/382,10,P
                              \###\\\\BUN\\\\\\
                    43/382,10,P,1
                              0
                    43/382,10,P,1,1
                              N\12
                    43/382,110\
                    43/382,11,I
                    43/382,11,I,1
                              0
                    43/382,11,I,1,1
                              N\0.93

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,11,P
                              \###\\\\CREA\\CRE\\\\
                    43/382,11,P,1
                              0
                    43/382,11,P,1,1
                              N\0.93
```

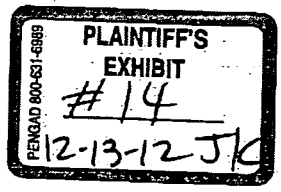
[redacted].TXT

```
                    43/382,130\
                    43/382,13,I

                    43/382,13,I,1
                              0
                    43/382,13,I,1,1
                              N\8.0
                    43/382,13,P
                              \1#*![8.7-10.2] MG/DL#*#L\\\\CA\\\\\\
                    43/382,13,P,1
                              0
                    43/382,13,P,1,1
                              N\8.0
                    43/382,170\

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,17,I

                    43/382,17,I,1
                              0
                    43/382,17,I,1,1
                              N\0.5
                    43/382,17,P
                              \###\\\\TBIL\\\\\\
                    43/382,17,P,1
                              0
                    43/382,17,P,1,1
                              N\0.5
                    43/382,180\
                    43/382,18,I

                    43/382,18,I,1
                              0
                    43/382,18,I,1,1
                              N\0.3
                    43/382,18,P
                              \###\\\\DBIL\\\\\\

Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,18,P,1
                              0
                    43/382,18,P,1,1
                              N\0.3
                    43/382,200\
                    43/382,20,I

                    43/382,20,I,1
                              0
                    43/382,20,I,1,1
                              N\6.9
                    43/382,20,P
                              \###\\\\TP\\\\\\
                    43/382,20,P,1
                              0
                    43/382,20,P,1,1
                              N\6.9
                    43/382,210\
                    43/382,21,I


Date      Time      Q Trn#      Data
--------  --------  - ----      ----
                    43/382,21,I,1
                              0
                    43/382,21,I,1,1
                              N\3.9
                    43/382,21,P
                              \###\\\\ALB\\\\\\
                    43/382,21,P,1
                              0
                    43/382,21,P,1,1
```

Russell v. Gill and Pennsylvania Life Ins. Co.
C/A No. 2010-CP-10-1144
NMRS File No. 15878/01509



Nelson Mullins Riley & Scarborough LLP
[PLIC 0428]



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~

Mike Russell Policy No. [redacted]9360
Chart of Benefit Payments

Date Report Signed	Date Report Received	Check Date	Check No.	Amount
08/27/08	09/04/08	09/22/08	BD310325689	$ 8,125.00
10/03/08	10/07/08	10/09/08	4210002410	$ 2,500.00
11/03/08	11/12/08	11/14/08	4210005455	$ 2,500.00
12/09/08	12/17/08	12/23/08	4210008506	$ 2,500.00
unsigned	01/28/09			
01/28/09	02/04/09	02/11/09	4210013923	$ 5,000.00
03/10/09	03/13/09	03/16/09	4210016833	$ 2,500.00
04/06/09	04/08/09	04/10/09	4210019546	$ 2,500.00
04/29/09	05/08/09	05/20/09	4210022422	$ 2,500.00
06/15/09	06/24/09	07/06/09	4210027524	$ 2,500.00
07/29/09	08/13/09	09/08/09	4210033163	$ 5,000.00
09/23/09	09/28/09	10/09/09	4210035890	$ 2,500.00
10/21/09	10/27/09	11/13/09	4210038663	$ 2,500.00
12/02/09	12/08/09	01/12/10	4210043769	$ 5,000.00
01/25/10	01/28/10	02/12/10	4210046455	$ 5,000.00
03/01/10	03/05/10	03/15/10	4210049058	$ 2,500.00
04/05/10	04/12/10			
06/17/10	06/22/10	07/20/10	4210059426	$ 7,500.00
08/19/10	08/23/10	08/26/10	4210062075	$ 5,000.00
		09/23/10	4210064481	$ 2,500.00
09/22/10	09/28/10	10/18/10	4210066774	$ 5,000.00
11/02/10	11/08/10	11/22/10	4210069375	$ 2,500.00
12/08/10	12/13/10	12/20/10	4210071712	$ 2,500.00
01/13/11	01/18/11	01/26/11	8810702344	$ 2,500.00
02/17/11	Unknown	03/02/11	8810713313	$ 2,500.00
		03/09/11	8810714771	$ 333.33
03/23/11	03/29/11	04/01/11	8810720061	$ 2,500.00
		04/29/11	8810728796	$ 2,500.00
04/28/11	05/02/11	05/27/11	8810736498	$ 2,500.00
05/26/11	06/02/11			
07/01/11	07/11/11	07/27/11	8810751432	$ 5,000.00
08/03/11	08/08/11	08/24/11	8810758384	$ 2,500.00
08/26/11	09/01/11	09/28/11	8210009105	$ 2,500.00
10/04/11	10/11/11	10/26/11	8810773923	$ 2,500.00
		11/23/11	8810780557	$ 2,500.00
12/21/11	12/27/11	12/28/11	8810788164	$ 2,500.00
		01/23/12	8210011101	$ 2,500.00
01/25/12	01/30/12	03/01/12	8810801176	$ 2,500.00
02/28/12	03/05/12	03/28/12	8810806996	$ 2,500.00
03/29/12	04/03/12	04/25/12	8810813434	$ 2,500.00
05/08/12	05/15/12	05/23/12	8810819713	$ 2,500.00
06/12/12	06/18/12	06/29/12	8810828330	$ 2,500.00
07/16/12	07/20/12	07/25/12	8810833168	$ 2,500.00
08/21/12	08/27/12	08/29/12	8810840118	$ 2,500.00
09/25/12	10/01/12	10/17/12	8810850706	$ 2,500.00
10/31/12	11/05/12	11/14/12	8810855783	$ 2,500.00
		11/30/12	8810859249	$ 2,500.00
				$ 135,958.33

PLAINTIFF'S EXHIBIT #16 12-13-12 JK
PENGAD 800-631-6989

PLIC 0671

PICK LIST COVER SHEET

Policy Number: [redacted]9360

Name: MIKE RUSSELL

Issue State: SC

Company: PLIC

- Please attach this page to succeeding pick list and place in Insured's file.

NBWEL
NBWEL
PRIVACY1
PRIVACY2
PRIVACY3
PRIVACY4
MCF310B
P19001SC
P19002SC
PAGE3
PAGE3A
PAGE3B
P19004SC
P19005SC
P19006SC
P19007SC
PR1901F
PR1901B
PR1903SC
P1904SC1
P1904SC2
P1911SC1
P1911SC2
P1914SC1
P1914SC2
P1914SC3
PR19461-1196
PR19462-1196
PR301SC1-397
PR301SC2-397
PICKLST

PLIC 0673

1 800 Ask Penn

Randy Gill

608 0600

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

PLAINTIFF'S EXHIBIT 17 12-13-12 JC

PENGAD 800-631-6989

ACCIDENT SICKNESS PROTECTION

PENNSYLVANIA LIFE INSURANCE CO

ACCIDENT SICKNESS
PROTECTION

If You Qualify

Are You Prepared for...

Disabling Accident?

Disabling Sickness?

Unexpected Surgical Procedure?

Hospitalization?

When disability prevents you from earning an income, you can continue to remain financially stable with an insurance plan to help meet your monthly obligations.

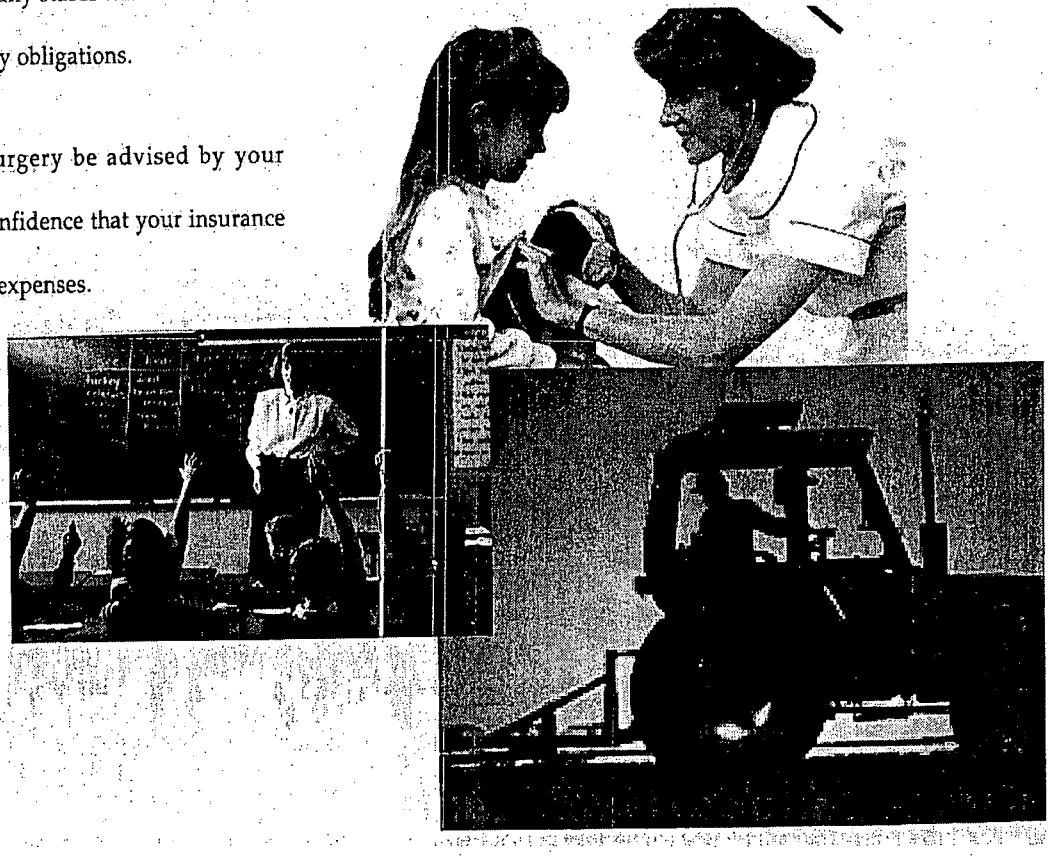
Should hospitalization or surgery be advised by your physician you can have the confidence that your insurance plan will help you meet these expenses.

Guaranteed Renewable

Coverage is guaranteed renewable in accordance with your specific state requirements.

The Best Defense is a Good Offense

Put together a plan for protection when the unexpected happens. Choose the insurance benefits that will keep you and your family worry free during times of financial stress.



1900

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 2610 Wycliff Road, Raleigh, North Carolina 27607

JUL 09 2002

APPLICATION FOR INSURANCE

POLICYHOLDER

DATE (M M D D Y Y Y Y): 06 27 2002

MAIL PREMIUM NOTICES: BUSINESS ✓ RESIDENCE ✓

POLICY NO. [redacted] 9360 INCREASE NEW CURRENT ✓

INSURED NAME

LAST: Russell SUFFIX FIRST: Mike MI SOCIAL SECURITY NUMBER: [redacted]

ADDRESS (Street/Rural Route): [redacted] ADDRESS (Line 2)

CITY: [redacted] STATE ZIP CODE COUNTY

AREA CODE/ TELEPHONE: [redacted] 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: Rts. home - Siding

EMPLOYER: Self AREA CODE/ TELEPHONE: 803 513 0575 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

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 50.8	4000 max	max	max
ACCIDENT EMERGENCY TREATMENT* (1946) 39.50	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	$		
SUBTOTAL	$ 27380	$	$
WAIVER OF PREMIUM YES	$ 458.92	113.87	TOTAL MODE PREMIUM: 4130
(Waiver of Premium will apply to any Monthly ADB Riders included)		(INC ROP 90.35)	
TOTAL PREMIUM - ALL COVERED INSUREDS	$ 36415		$ 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

Definitions, Exceptions and Limitations

INJURY means accidental bodily injury sustained directly and independently of disease or bodily infirmity, or any other cause while your coverage is in force.

SICKNESS means sickness or disease first manifesting itself more than 30 days after the issue date of the sickness rider and while your coverage is in force.

TOTAL DISABILITY means that you or your Covered Spouse are unable to engage in any employment or occupation for which you or your Covered Spouse are, or become, qualified by reason of education, training or experience.

TOTAL DISABILITY Coverage ends at age 65. However, if you are working full time your benefit will continue to age 70. When your Disability Benefit ends it will automatically convert to Hospital Confinement paid to you from the first day you are confined in a Hospital - even for life.

HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity; being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state -- serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF_____ Date_____, _____ the sum of _____ Dollars _____ Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $_____

LICENSED AGENT_____

AGENT LICENSE NUMBER_____

ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

PI-1900 A/S NC 12.96

ACCIDENT SICKNESS PROTECTION

If You Qualify

Which Program Best Fits Your Needs?

Accident Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	ADB Amount	Options IP	Options WP	Premium Total
		$ 500	7 days	Life yrs.	$	$ 4000	$ 2000	$ 75000			$ 135.32 / mo.
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$

Incremental Cost $ _____

Sickness Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	Options IP	Options WP	Premium Total
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$

Incremental Cost $ _____

Paid $82 diff. for 2 mo's. Pd $135.32 / mo Diff

Monthly Disability Benefit

Present Income	Disability Income Benefit
$4,000 per month	$2,000 per month
$3,600 per month	$1,800 per month
$3,000 per month	$1,500 per month
$2,400 per month	$1,200 per month
$2,000 per month	$1,000 per month
$1,600 per month	$800 per month
$1,200 per month	$600 per month
$800 per month	$400 per month
$400 per month	$200 per month

(Monthly benefit not to exceed 50% of present income)

ROA 2390

PI 1900 A/S NC 12.96

CN 96-1577

Definitions, Exceptions and Limitations

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HOSPITAL means a facility which other than incidentally, must not be: (a) a clinic; (b) a nursing home; (c) a rest home; (d) a convalescent home; (e) an extended care facility; (f) a hospice; (g) a place set up mainly to treat alcoholics or drug addicts; or (h) a home for the aged.

PHYSICIAN means a currently licensed practitioner of the healing arts excluding you and members of your immediate family.

COVERED FAMILY MEMBERS means you, your spouse, and your dependent and adopted children who are named on the application and who are eligible under the terms of the Eligibility and Termination Provision of your policy.

PRE-EXISTING CONDITION means those conditions for which medical advice or treatment was received or recommended or that could be medically documented within the one-year period immediately preceding the rider effective date. Your Sickness benefits will not cover a loss that starts within one year after the Sickness Rider Date and is caused by a Pre-existing Condition. *The Pre-existing Condition limitation does not apply to persons age 65 or over on the Sickness Rider Date.*

EXCEPTIONS AND LIMITATIONS Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: suicide or attempted suicide; intentionally self-inflicted injury; while in any military or naval service; war or any act of war; voluntary participation in riot or insurrection; mental or emotional disorders; alcoholism or drug addiction; normal pregnancy and childbirth, except for complications of pregnancy; engaging in any organized speed contest; from service, travel or flight in any aircraft except as a fare-paying passenger; or from dental treatment except when such treatment is due to Injury to natural teeth or gums; engaging in an illegal occupation or felonious activity, being intoxicated, or from being under the influence of any narcotic unless taken on the advice of a Physician.

GUARANTEED RENEWABLE: This coverage is guaranteed renewable to age 85 upon the timely payment of the renewal premium then in effect. After age 85 the program is renewable at our option, but if we refuse to renew, we must do so on all policies issued for all people just like you in your state and we must give you sufficient notice of non-renewal. We reserve the right to change your premium, but if we do, we must make the same rate change for all people just like you in your state, but not more than once a year.

ACCIDENTAL DEATH BENEFIT: Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an injury within 90 days of the accident.

THIS IS NOT A CONTRACT but a brief description of the principal provisions, which are available only through a combination of Policy Form P-1900 and Rider Forms PR-1901, PR-1902, PR-1903, PR-1904, PR-1905, PR-1906, PR-1911, PR-1912, PR-1914, PR-1915 and PR-1916. **This is limited coverage.**

Receipt

PENNSYLVANIA LIFE INSURANCE CO.

HOME OFFICE: Lemoyne, Pennsylvania
EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

Pennsylvania Life Insurance Company is a legal reserve company authorized to transact business in your state -- serving policyholders from coast to coast in the United States and Canada.

RECEIVED OF (232.74) Mickissick Date 7/5/02 the sum of 232 Dollars 74 Cts. as first Annual ☐ Semi-Annual ☐ Monthly ☐ payment on application under corresponding date. Acceptance of this Receipt by the applicant in exchange for payment made by him/her shall signify complete understanding and satisfaction with the entire transaction. No representation or agreement not therein embodied shall be binding on the Company. The application shall not be binding upon the Company until approved by the Company. In the event the application is rejected, the above amount will be refunded in full by the Company.

TOTAL ANNUAL PREMIUM $ 931.-

LICENSED AGENT Randolph Gill
AGENT LICENSE NUMBER 173416
ADDRESS _____

MAKE CHECK PAYABLE TO PENNSYLVANIA LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

PI-1900 A/S NC 12.96

ACCIDENT SICKNESS PROTECTION

If You Qualify

Which Program Best Fits Your Needs?

Accident Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	ADB Amount	Options IP	Options WP	Premium Total
Mike Russell		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$
		$	days	yrs.	$	$	$	$			$

Incremental Cost $_____

Sickness Benefits

Name	Age	Monthly Disability	Elimination Period	Benefit Period	Hospital Daily Rate	Surgery Benefit	Outpatient Surgical	Options IP	Options WP	Premium Total
Mike Russell	29	$2500	days	yrs.	$	$500	$250			$ 931
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$
		$	days	yrs.	$	$	$			$

Incremental Cost $_____

Monthly Disability Benefit

Present Income	Disability Income Benefit
$4,000 per month	$2,000 per month
$3,600 per month	$1,800 per month
$3,000 per month	$1,500 per month
$2,400 per month	$1,200 per month
$2,000 per month	$1,000 per month
$1,600 per month	$800 per month
$1,200 per month	$600 per month
$800 per month	$400 per month
$400 per month	$200 per month

(Monthly benefit not to exceed 50% of present income)

ROA 2392

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	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

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. 6 DAY 27 YEAR 02

POLICY NO. (if applicable) [redacted]9360

Date of Birth: MO. DAY YEAR [redacted]

Social Security No: [redacted]

PRIMARY INSURED NAME: Mike Russell

ADDRESS: [redacted] 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 1 2000

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		RCL				20.50

P-A-300 Ed. 3-97

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

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: South Trust Bank

CITY, STATE & ZIP CODE: Columbia SC

NAME OF ACCOUNT: Susanna P Russell & Michael C Russell

6 4 — 2 5

BANK ROUTING NO.

[redacted] ACCOUNT NO.

7/5/02 ✓

DATE — SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

7 (Month) 5 (Day) 02 (Year) on Mike Russell (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

B.

NB RNWL

☐ ☑ Policy Number _____ effective for premiums due on and after 10 (Month) 5 (Day) 02 (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

P-688 12.98

(POLICYHOLDER COPY)

ROA 2397

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and

(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and

(3) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and

4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____

J. Peter Kusev, Secretary

P-688 12.98

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this 5th day, month of July, 2002

Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

PENNSYLVANIA LIFE INSURANCE COMPANY

HOME OFFICE: Lemoyne, Pennsylvania EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

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) Russell Alice		A. GROSS INCOME LAST YEAR 120000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 30 000
DUTIES Install hard flooring		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS 6		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES 8	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] 173416

Signature of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

Lexington SC 9/15/20

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

PENNSYLVANIA LIFE INSURANCE CO.

EXECUTIVE OFFICES: 600 Courtland Street, Orlando, Florida 32804

UNDERWRITING AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I AUTHORIZE any medical professional, medical care institution, consumer reporting agency, insurance institution, insurance support organization, institutional source, governmental agency including but not limited to the Social Security Administration and the Veteran's Administration, the Medical Information Bureau, employer or any other individual or person to provide the Company named above, its officers, employees, agents, or its reinsurers; with any and all medical record and personal information, including privileged information, requested about me or any of my minor children insured or to be insured under the terms stated herein. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company named above to collect and transmit such information.

As part of the Company's underwriting procedure for processing applications for insurance, an investigative report by a consumer reporting agency may be made concerning you and any person requesting insurance whereby information is obtained from personal interviews with neighbors, friends, associates, or others acquainted with you, and those to be insured, as to character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation and for a written summary of your rights as a consumer. This written request should be directed to the Company at 600 Courtland Street, Orlando, Florida 32804.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Company named above, or its agents, to determine eligibility for insurance.

I KNOW that I or my legal representative may request to receive a copy of his Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization will be valid from the date signed for a period of two and one half (2 1/2) years.

Signed this 27th day, month of June, ____

_____	_____
Name of Minor Child	Signature of Proposed Insured or Parent of Minor Child
_____	_____
Name of Minor Child	Signature of Spouse if to be Insured

NOTICE WITH REGARD TO THE MEDICAL INFORMATION BUREAU (MIB)

We will treat the data you give us in confidence; we or our reinsurers, may make a brief report to the MIB. MIB is a non-profit data center of which most life companies are members; it collects and exchanges data on behalf of its members. It will give the data in its files about you only to a member life company to which you have applied for a policy or make a claim.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the data in your file, you can ask that it be corrected by using the method set forth in the Federal Fair Credit Report. Write to the MIB at: P.O. Box 105, Essex Station, Boston, MA 02112; or call (617) 426-3660. The Company named above and its reinsurers may also give data about you to other life companies, if you apply to them for a policy or make a claim.

Distribution - White - Attached to Application / Yellow - Applicant's Copy

MCF-159 10.97

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE PENNSYLVANIA LIFE INSURANCE COMPANY, RALEIGH, NORTH CAROLINA

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks drawn on my account by and payable to the order of the Pennsylvania Life Insurance Company, Raleigh, North Carolina, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

TO: BANK: SouthTrust Bank

CITY, STATE & ZIP CODE: Columbia SC

NAME OF ACCOUNT: Suzanne C Russell & Michael C Russell

6 4 — 2 5

ACCOUNT NO. [redacted]

4 1 0

BANK ROUTING NO.

6/27/02 [signature]

DATE — SIGNATURE (EXACTLY) AS IT APPEARS ON BANK RECORDS

Note To Depositor: A voided preprinted blank check or preprinted deposit slip must accompany this form.

POLICIES TO BE PAID UNDER CHECK-O-MATIC PLAN

A. The policy issued pursuant to an application dated

6 (Month) 27 (Day) 02 (Year) on Alice Russell (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

_____ (Month) _____ (Day) _____ (Year) on _____ (Name of Proposed Insured)

B.

NB RNWL

☐ ☑ Policy Number [redacted]936a effective for premiums due on and after 8 (Month) 19 (Day) 02 (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

☐ ☐ Policy Number _____ effective for premiums due on and after _____ (Month) _____ (Day) _____ (Year)

P-688 12.98

(POLICYHOLDER COPY)

ROA 2402

TO: The Bank named above:

In consideration of your participating in a plan which the Pennsylvania Life Insurance Company, (hereinafter known as the "Company") has put into effect by which amounts due on policies of insurance are collected by checks, drawn by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check, draft or order, whether or not genuine, drawn by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you, whether with or without cause, or intentionally or inadvertently, of any such check, draft or order, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check, draft or order; and
(2) It will defend at its cost and expense any action which may be brought by any depositor or any other person because of any action taken pursuant to or in any manner arising out of your participation in the pre-authorized check plan for premium collection; and
(3) Without limitation on the foregoing Indemnities, it will refund to you any amount erroneously paid by you on any such check, draft or order if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check, draft or order on which such erroneous payment was made; and
4) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other. Likewise, your participation and that of Pennsylvania Life Insurance Company may be terminated by thirty days' written notice from either party to the other.

Authorized in a resolution adopted by the Board of Directors of:

Pennsylvania Life Insurance Company — Raleigh, North Carolina

By _____
J. Peter Kusev, Secretary

P-688 12.98

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) Ross Russell		A. GROSS INCOME LAST YEAR 130,000
TITLE Owner		B. OPERATING EXPENSES LAST YEAR 33,000
DUTIES		A-B= NET INCOME LAST YEAR 90,000
YEARS IN BUSINESS		MONTHLY DRAW (IF ANY) LAST YEAR
NO. OF EMPLOYEES	SS#	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 of Licensed Agent Agent #

Signature of Licensed Agent Agent #

Application signed at:

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 of Applicant

MCF-416 NC-P ED. 4-95

PRIVACY NOTICE TO OUR CUSTOMERS

THIS NOTICE IS FOR YOUR INFORMATION. NO RESPONSE IS REQUIRED.

Universal American Financial Corp and its subsidiary insurance companies: American Exchange Life Insurance Company, American Pioneer Life Insurance Company, American Progressive Life and Health Insurance Company of New York, Constitution Life Insurance Company, Marquette National Life Insurance Company, Peninsular Life Insurance Company, Pennsylvania Life Insurance Company, and Union Bankers Insurance Company strongly believe in protecting the confidentiality and security of information we collect about you. This notice refers separately to each of the companies by using the terms "us," "we," or "our." This notice describes our privacy policy and describes how we treat the information we receive ("Information") about you.

Why We Collect and How We Use Information: We collect and use Information for business purposes with respect to our insurance and other business relationships involving you. These business purposes include evaluating a request for our insurance or other products or services, evaluating benefit claims, administering our products or services and processing transactions requested by you. We may also use Information to offer you other products or services we provide.

How We Collect Information: We get most Information directly from you. The Information that you give us when applying for our products or services generally provides the Information we need. If we need to verify Information or need additional Information, we may obtain Information from third parties such as adult family members, employers, other insurers, consumer reporting agencies, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations or other personal characteristics as well as transactions with us or with others.

How We Protect Information: We treat Information in a confidential manner. Our employees are required to protect the confidentiality of Information. Employees may access Information only when there is an appropriate reason to do so, such as to administer or offer our products or services. We also maintain physical, electronic and procedural safeguards to protect Information; these safeguards comply with all applicable laws. Employees are required to comply with our established policies.

Information Disclosure: We may disclose any Information when we believe it necessary for the conduct of our business, or where disclosure is required by law. For example, Information may be disclosed to others, including independent agents or brokers who sell our products and services, to enable them to provide business services for us, such as helping us to evaluate requests for insurance or benefits, to perform general administrative activities such as maintaining existing accounts, or to otherwise assist us in servicing or processing an insurance product or service requested or authorized by you. Information may also be disclosed for audit or research purposes, or to law enforcement and regulatory agencies, for example, to help us prevent fraud. Information may be disclosed to others that are outside of our family of companies, such as companies that process data for us, companies that provide general administrative services for us, other insurers, and consumer reporting agencies. We will make other disclosures of Information as permitted by law.

We may also provide Information: (i) to others outside of our family of companies, such as marketing companies, independent agents and brokers, to assist us in offering our products and services to you, and (ii) to financial services companies outside of our family of companies with which we have a joint marketing agreement, such as an agreement with another insurer to enable us to offer you that insurer's products. Companies with which we share customer Information are required to maintain the confidentiality of that Information. We do not make any other disclosures of Information to other companies who may want to sell their products or services to you. For example, we will not sell your name to a catalog company. We may disclose any Information other than a consumer report or health Information for the purposes described in this paragraph.

Access to and Correction of Information: Generally, upon your written request, we will make available Information for your review. Information collected in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that the Information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of Information.

Further Information: In addition to any other privacy notice we may provide, a recently enacted federal law established new privacy standards and requires us to provide this summary of our privacy policy annually. You may have additional rights under applicable laws. For additional Information regarding our privacy policy, please write to us.

Benefit Options Available*

ACCIDENT

Accident Total Disability

Accident Total Disability Benefit is paid to you each month while you are Totally Disabled due to injury from the date the elimination period ends, if any, up to the maximum benefit period allowed. Total Disability must start within 30 days of the accident. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability ends.)

Accident Surgical Benefit

Benefits payable to you for Surgery as a result of an Injury. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Accident Hospital Benefit

Hospital Benefits paid to you from the first day you are hospitalized as a result of injury for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Accidental Death Benefit

Accidental Death Benefit is paid in one lump sum to your Beneficiary if you should die as a result of an Injury within 90 days of the accident.

Waiver of Premium Benefit - Accident

Premium Waived If You Are Totally Disabled from an accident.
If you are totally disabled for six months or more as a result of an Injury, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

SICKNESS

Sickness Total Disability

Sickness Total Disability Benefit is paid to you while you are Totally Disabled as a result of Sickness. Benefits payable from the date the elimination period ends up to the maximum benefit period allowed. You must be under the Regular and Personal Care of a Physician. (See your Rider for information on when Total Disability due to Sickness ends.)

Sickness Surgical Benefit

Benefits payable to you for Surgery as a result of Sickness. The surgery must be performed by a Physician while you are a resident patient in a Hospital. If surgery is performed on an outpatient basis, one half of the surgical benefit is payable. The covered surgical procedures are listed in the Surgical Schedule section of your policy. If two or more surgical procedures are performed, we will pay the benefit for the most expensive of the procedures performed.

Sickness Hospital Benefits

Hospital benefits paid to you from the first day you are hospitalized as a result of Sickness for as long as you are hospitalized - even for life. Hospital Confinement must be recommended by a Physician.

Waiver of Premium Benefit - Sickness

Premium Waived If You Are Totally Disabled from sickness.
If you are totally disabled for six months or more as a result of Sickness, we will waive any premium that comes due as long as your disability continues. The disability must begin prior to the policy anniversary following your 65th birthday. Your premium payments will begin again on the next premium due date after your disability ends.

Inflation Protection

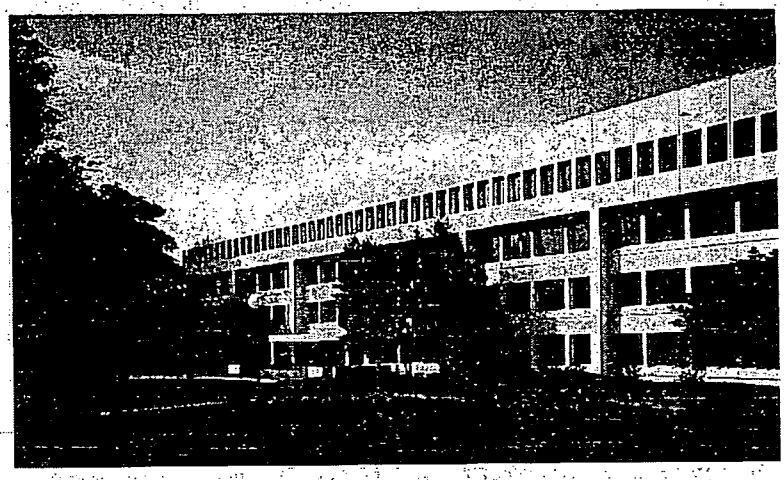
5% per year increase in benefits to 50% total increase after 10 yrs.

We will increase your daily benefit 5% per year for 10 years, if you have had continuous coverage. At the end of 10 years, your daily Injury and/or Sickness benefits are 150% of the original amount. The benefit for any claim will be fixed for its duration as of the date it starts.

**Benefit descriptions, definitions, exclusions and limitations may vary by state. Please refer to your policy/rider and the insert sheet enclosed. Benefits applied for are listed in your application. No coverage is in force unless approved by the Company.*

Safe, Solid, Stable

Pennsylvania Life Insurance Company is licensed to do business in 49 states, the District of Columbia and Canada. We underwrite, market and service a wide variety of insurance coverage including life, accident and health.



Our Policy-holder First Philosophy

With more than a half million policyholders, Pennsylvania Life Insurance Company's US operations has made substantial investments in technology in order to create and upgrade the kind of system required to provide every customer with top quality, responsive service. Although we manage more than 2,600 claims each month and pay more than $4,500,000 in benefits every month, we're only as good as the satisfaction of the last customer.

The Personal Approach

Pennsylvania Life is not a small company. With over 100 offices throughout the United States and Canada, we are a substantial company. But we haven't grown to our current size by ignoring our customers or creating large, unresponsive bureaucracies and annoying paperwork.

Our highly trained insurance professionals have built their success on your satisfaction. You'll find their personal approach to service is a welcome change to the way most businesses operate. It also means that your insurance representative will build a program of adequate, customized coverage based on your needs, rather than an off-the-shelf product line.

We've been in business for over 100 years because we're an insurance company that has never lost sight of why we're in business... to provide our customers with the insurance coverage they need when they need it the most.

PENNSYLVANIA LIFE INSURANCE CO.
600 Courtland Street, Orlando, Florida 32804

PB-1900 A/S Rev. 10.98

CN 96-0102

Code of Laws of South Carolina 1976 Annotated
Title 38. Insurance
Chapter 71. Accident and Health Insurance
Article 1. General Provisions

Code 1976 § 38-71-30

§ 38-71-30. Whole contract, including application, must appear in policy; oral applications.

Currentness

Every insurer doing accident or health insurance business in the State shall deliver with each policy of insurance issued by it a copy of the application made by the insured so that the whole contract appears in the application and policy of insurance. If the insurer violates this requirement, no defense is allowed to the policy on account of anything contained in or omitted from the application. If the insurance policy is issued upon an oral application, no defense is allowed to the policy on account of anything contained in or omitted from the oral application.

Credits

HISTORY: Former 1976 Code § 38-9-70 [1947 (45) 322; 1949 (46) 600; 1952 Code § 37-146; 1962 Code § 37-146; 1980 Act No. 305, § 1] recodified as § 38-71-30 by 1987 Act No. 155, § 1.

Notes of Decisions (4)

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Code 1976 § 38-71-30, SC ST § 38-71-30
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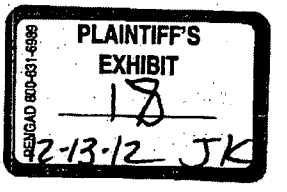

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BETTIA CARRIGG
CLERK OF COURT

STATE OF SOUTH CAROLINA) COUNTY OF LEXINGTON)	IN THE COURT OF COMMON PLEAS
Mike Russell, Plaintiff,) vs.) Randolph Gill and Pennsylvania Life Insurance Company,) Defendants.	Civil Action No. 2011-CP-32-4981 **DEFENDANT PENNSYLVANIA LIFE INSURANCE COMPANY'S MOTION TO ALTER OR AMEND ORDER**

YOU WILL PLEASE TAKE NOTICE that, pursuant to Rule 52(b) of the South Carolina Rules of Civil Procedure, the Defendant, Pennsylvania Life Insurance Company ("Penn Life"), by and through its undersigned attorneys, will move before the Court of Common Pleas for the Eleventh Judicial Circuit on the tenth (10th) day after service hereof, or as soon thereafter as counsel may be heard, for an Order altering and amending the Order of the Court filed on June 11, 2013. Written notice of the entry of the Court's Order was received by counsel for Penn Life on June 17, 2013. This motion is based on the following grounds.

1. The Court ruled in its Order that the intoxication exclusion in the insurance policy was unenforceable because there was a lack of evidence that the policy had been delivered to the Plaintiff. (Order ¶ 39). In making this ruling, the Court relied on § 38-71-30 of the South Carolina Code. This statute, however, mandates only that "the application" be provided with the policy "so that the whole contract appears in the application and policy of insurance." S.C. Code Ann. § 38-71-30 (Law. Co-op. 2002). Thus, the purpose of the statute is to incorporate the contents of the application into the contract between the insurer and insured. The statute specifies the penalty for failure to comply, prohibiting an insurer from asserting a defense to the policy based on anything included or omitted from the application. *Id.* Nowhere in the statute

does it provide that an insurer loses the ability to rely on an exclusion contained in the policy. The fact that the statute includes an express penalty prohibiting reliance on information in the application but no penalty affecting the enforceability of exclusions demonstrates the intent of the legislature to leave exclusions unaffected by noncompliance with the statute. *See Hodges v. Rainey*, 341 S.C. 79, 86, 533 S.E.2d 578, 582 (2000) (applying cannon of statutory construction that "to express or include one thing implies the exclusion of another"). Moreover, while insurers strive to deliver their policies (and the testimony of Jack Mackin established that Penn Life had procedures in place for this purpose), the statute does not explicitly require the delivery of policies, but instead is worded to ensure the application is made part of the insurance contract.

2. There is no statute or case law in South Carolina which requires that the Court invalidate a policy exclusion based on a finding that delivery did not occur. Indeed, South Carolina law is clear that the courts cannot be used as a vehicle to re-write insurance contracts. *See Dean v. American Fire & Cas. Co.*, 249 S.C. 39, 41, 152 S.E.2d 247, 248 (1967) ("[T]he courts have no authority to change the contract in any particular and have no power to interpolate into the agreement between the insurer and the insured a condition or stipulation not contemplated by the contract between the parties."). Here, the Court found in Paragraph 16 of the Order that the policy issued in response to the Plaintiff's application and reflected in the records of Penn Life contained an intoxication exclusion. There is no law in South Carolina that would allow for the selective enforcement of policy provisions requiring benefit payments while at the same time allowing the Court to disregard exclusions or limitations. This is especially true where, as here, the exclusion is one specifically permitted by statute. *See* S.C. Code Ann. § 38-71-370(9) (Law. Co-op. 2002) (expressly authorizing inclusion of intoxication exclusion in accident disability policies).

3. The evidence also establishes that the Plaintiff had notice of the existence of the intoxication exclusion in the policy years before his motorcycle wreck. On June 27, 2002, the Plaintiff met with insurance agent Randolph Gill and completed an application requesting an additional monthly benefit of $500 for his policy originally purchased in 1999. (Def.'s Exh. 11). This application was intended to increase his total monthly benefit to $2,500.

4. At the time of the completion of the application in 2002, Mr. Gill presented the Plaintiff with a receipt indicating he had received from the Plaintiff a premium payment for the insurance policy. Defendant's Exhibit 12 was a copy of that receipt bearing the signature of Mr. Gill. As noted by the Court in Paragraph 3 of the Order, the Plaintiff acknowledged that he received the receipt from Mr. Gill.

5. At the top of the receipt form is the title "Definitions, Exceptions and Limitations." (Def.'s Exh. 12). One of the paragraphs in the body of the form bears the heading in all capital typeface, "EXCEPTIONS AND LIMITATIONS." (*Id.*) That paragraph states in pertinent part, "Your coverage does not cover loss that occurs outside the US, Canada and Mexico, or that results from any of the following: . . . being intoxicated." (*Id.*)

6. The Plaintiff cannot claim any prejudice from the purported absence of delivery of the policy because he was on notice of the existence of the intoxication exclusion as disclosed in the receipt provided by the insurance agent. Moreover, there can be no prejudice because the excluded activity is illegal when combined with operating a motor vehicle, as was done by the Plaintiff. Thus, regardless of the Plaintiff's knowledge of the exclusion, he should not have been driving after a significant consumption of alcohol. Without a showing of prejudice, Penn Life cannot be estopped from relying on the intoxication exclusion. *See Stringer v. State Farm Mut. Auto. Ins. Co.*, 386 S.C. 188, 687 S.E.2d 58 (Ct. App. 2009) (refusing to find estoppel against insurer where insured could not show prejudicial change of position).

7. Courts from other jurisdictions have addressed the issue as to the effect of delivery on policy exclusions and determined that lack of delivery of the policy does not render the policy's exclusions ineffective.

a. In *Neely v. Am. Family Mut. Ins. Co.*, 123 F.3d 1127 (8th Cir. 1997) (applying Iowa law), the Eighth Circuit held: "[We] reject the . . . contention that . . . failure to deliver the insurance policy estops [the insurer] from enforcing the exclusionary clause." *Id.* at 1130. The *Neely* court pointed out that the policyholder had "not shown that under Iowa law, the failure to deliver an exclusionary clause results in the per se inability to enforce the clause," and that it did "not believe that Iowa law support[ed] such a conclusion." *Id.* at 1130 n.4.

b. In *Cmty. Bank v. Progressive Cas. Ins. Co.*, No. 1:08-cv-1443-WTL-WGH, 2010 U.S. Dist. LEXIS 75608 (S.D. Ind. July 27, 2010), the court held that lack of delivery does not have an effect on the policy's exclusions. The court explained: "[Plaintiff] has not cited a single case to indicate that, under Indiana law, the failure to deliver an insurance policy or exclusionary clause results in the per se inability to enforce the clause," and "the court's own research [has not] revealed any case law dictating this result." Id. at *6-7. Thus, the court found that "[Plaintiff's] 'estoppel' argument is unpersuasive," and ultimately granted summary judgment. *Id.* at *7, *10.

c. The courts in Ohio have reached the same conclusion. *See Williams v. Permanent Gen. Assur. Corp.*, 2002 Ohio 4445, 2002 Ohio App. LEXIS 4589, at *8–9 (Ohio Ct. App. 2002) ("[T]he exclusionary language within the policy was effective despite the failure to deliver the policy."); *Jones v. Cincinnati Ins. Co.*, No. 96 CA 43, 1999 Ohio App. LEXIS 2827, at *10 (Ohio Ct. App. June 21, 1999) (holding lack of delivery irrelevant, stating "such a policy would not have been issued without said exclusion. Therefore, . . . the exclusionary language was applicable and the insurer was entitled to a judgment as a matter of law.").

8. If the Court were to recognize the validity of the intoxication exclusion in this case, then it should find that the Plaintiff was intoxicated at the time of the motorcycle wreck and that his intoxication was a contributing, legal, and proximate cause of his injuries. Significant evidence in the form of medical records and other exhibits as well as testimony from two toxicology experts, a highway patrol trooper, and the driver of the vehicle with which the Plaintiff collided establishes that the Plaintiff was in fact intoxicated and that this was a contributing cause of the motorcycle wreck.

9. Based on the foregoing reasons, the Court should modify its Order to find that the intoxication exclusion is enforceable and that such provision excludes the Plaintiff's claim for disability benefits under the facts of this case. Judgment should therefore be entered in favor of Penn Life as to its counterclaim for declaratory judgment.

NELSON MULLINS RILEY & SCARBOROUGH LLP

By: _____

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Attorneys for Defendant Pennsylvania Life Insurance Company

Columbia, South Carolina

6/25, 2013

STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS
COUNTY OF LEXINGTON) 2011-CP-32-04981

MIKE RUSSELL)
PLAINTIFF)
vs.) TRANSCRIPT OF RECORD
)
RANDOLPH GILL and)
PENNSYLVANIA LIFE INSURANCE)
COMPANY)
DEFENDANTS)

October 15, 2013
Lexington, South Carolina

B E F O R E:

THE HONORABLE EUGENE C. GRIFFITH, JR., JUDGE

A P P E A R A N C E S:

S. JAHUE MOORE, ESQ.
Attorney for the Plaintiff

D. LAWRENCE KRISTINIK, III, ESQ.
Attorney for the Defendants

CAROL M. THUEME, RPR
Official Court Reporter

I N D E X

(There were no witnesses produced.)

EXHIBITS

(There were no exhibits marked.)

THE CLERK: Mike Russell versus Randolph Gill.

THE COURT: All right. Mr. Kristinik, this is your motion on behalf of Pennsylvania Life to reconsider or alter or amend. Let's hear it.

MR. KRISTINIK: Good morning, Your Honor.

THE COURT: Good morning. Sorry I was late. I thought y'all were first up, but I delayed myself in the periodontist's office, being inflicted pain. So I would rather have been here.

MR. KRISTINIK: Well, for that I think we would all agree with you.

Your Honor, thank you again for making time on your roster today to hear this motion under Rule 52B, to alter or amend your prior order.

As you recall, Your Honor heard four days of testimony during the trial of this matter in December, took it under advisement, reviewed the exhibits and testimony, came back and issued your ruling in favor of -- well, in favor of Pennsylvania Life, my client, on Mr. Russell's affirmative claims. But then you ruled in favor of Mr. Russell on Pennsylvania Life's claim for declaratory judgment seeking to enforce the intoxication exclusion. And so it's that part of your order that I would like to address.

THE COURT: Okay.

MR. KRISTINIK: And in the order, in the conclusion of the order, Your Honor decided that South Carolina Statute 38-71-30 requiring delivery of the policy and you found that Pennsylvania Life failed to provide proof of delivery satisfactory to the Court to establish the fact of delivery and, therefore, you found that the intoxication exclusion should not be enforced on that basis. And so I would like to specifically address your finding of non-delivery, more specifically, what the legal effect of that should be.

And I want to focus on a couple of things, bring a couple of things to your attention, because it's not clear from the order whether or not these facts were considered. I know the record was quite large, and so I want to make sure I bring these to your attention. First is Exhibit 12 -- Jake, this is a copy for you.

If I may approach, Your Honor.

THE COURT: Uh-huh.

MR. KRISTINIK: Defendant's Exhibit No. 12, it's entitled receipt -- well, it is a receipt, and at the top it's entitled, "Definitions, Exceptions, and Limitations." It's just a one-page document.

And the testimony in the record from Mr. Gill and Mr. Russell is that Mr. Russell received this document in 2002 at the time he was applying for an increase in his

coverage. The accident did not happen -- the wreck, the motorcycle wreck did not happen until years later.

Mr. Russell, he concedes that he received this. Your Honor recognized this in paragraph three of the order. But if you look on the right-hand side, the first full paragraph in all capital letters, the heading is "Exceptions and Limitations," and then it says: "Your coverage does not cover loss" -- and skimming some words -- "that results from any of the following," and it has a list of various exclusions. And then at the bottom it says, "being intoxicated." And it's our position that this clearly put Mr. Russell on notice that the policy had an intoxication exclusion and that he was provided this notice many years before the wreck. And on this basis alone, we would argue that the Court should enforce the intoxication exclusion regardless of how the Court finds on whether or not delivery of the policy occurred.

The next point I would like to make is that the statute upon which the Court relies in its order, 38-71-30, does not provide as penalty or consequence the invalidity or voiding of exclusions in the policy. In fact, it specifies what the penalty or the consequence is for noncompliance with the statute.

It says in the second sentence that "the insured violates this requirement, no defense is allowed to the

policy on account of anything contained in or omitted from the application."

So if you had a defense based on something in the application, the defendant insurer would be hampered by this statute. We're not relying on anything in the application. This is an exclusion in policy. So the consequence that's provided for in 38-71-30 doesn't address this situation we have here at all.

Now, there's another provision in Chapter 71 that I'd like to point out to the Court. In Section 38-71-90 entitled "Penalty for Violation of Chapter," it provides that if an insurer willfully violates the provisions of this chapter, then it's going to be subject to the provisions of 38-2-10 for each offense.

And if you go to the 38-2-10, it talks in terms of monetary penalties and jail time for willful violations. Nowhere in the insurance code does it provide that an exclusion will become unenforceable if there's noncompliance with some provision of the insurance code. So that leaves you to turn to the common law to answer this question.

There has been no case presented during any of these proceedings, no South Carolina appellate court case, which addresses the situation at all, and certainly no indication that says that an intoxication exclusion should

be voided if there's not delivery.

We were able to hear that he was on notice of the intoxication exclusion because of Exhibit 12, the receipt, which I provided to you just a moment ago.

Additionally, in addition to being on notice, there is no testimony that Mr. Russell was ever told that driving while under the influence would be covered by this policy. He was not misled into believing that DUI would be covered by the policy. He didn't suffer any prejudice. He had no expectation of coverage, no one told him there would be coverage for this. It didn't alter his behavior because he shouldn't be drinking and driving regardless. He should not be driving while intoxicated because it's illegal.

This is not a situation where the exclusion is something that he could legally be doing and might want to do. This exclusion relates to something he's never allowed to do. He should have no expectation that he can go out, perform illegal activities and be covered under this policy. But he's on notice of it regardless, because it was in the receipt that he acknowledges he received and was given to him by the agent, Mr. Gill.

We think that if Your Honor applies the law as we're advocating here and to conclude that he was on notice of the intoxication exclusion and therefore it

should be enforced, we think that the evidence at trial very, very heavily weighs in favor of a finding that Mr. Russell's intoxication on the evening of the wreck was a contributing cause of that wreck, and I just want to touch on a few of the facts.

First, we had two blood alcohol readings, .232 and then two hours later a sample and provided to SLED was a .199. There's no scientific evidence in the record disputing the accuracy of either one of those rulings.

And while Mr. Russell testified that he just had two or three Crown Royal drinks, both expert witnesses in trial, Dr. Richardson, William Richardson, and Lieutenant Wendy Bell from SLED, both of them expert toxicologists, both said you'd have to have a minimum of seven to ten drinks to get to that level. But there's no evidence disputing the accuracy of those readings. There's no expert testimony or other scientific evidence provided by Mr. Russell.

Mr. Russell contented, well, maybe the medical treatment caused this -- these high blood alcohol levels. But both Dr. Richardson and Lieutenant Wendy Bell testified on the stand that there's no medical treatment that would have affected these blood alcohol readings in any way.

With respect to what happened at the scene on

the exit ramp for exit number 15, Trooper Lawful testified that he arrived at the scene, he saw that Connie Collins' car was 99 percent off the roadway, just -- a tire just a couple of inches over the white line. He'd investigated over a thousand accidents. He said that no problem with a car, and certainly a motorcycle, to navigate that exit ramp. No problem getting past Ms. Collins' car, which was 99 percent of the road.

THE COURT: I thought the trooper was inexperienced, that he was there being trained by another guy.

MR. KRISTINIK: Trooper Lawful was the training trooper.

THE COURT: And the other trooper was the one who was coming to make the case. Okay. I know there were two there.

MR. KRISTINIK: There were two there, and it was the experienced one, Trooper Lawful, who was in the courtroom with Your Honor.

THE COURT: That's right. I wanted to make sure I didn't forget that or misremember it.

MR. KRISTINIK: He looked at -- he found physical evidence that also supported Connie Collins' version of the events. Connie Collins said, I dropped my cell phone, thought it went under my pedal. I pulled off

the road, my lights were on, hit my brake pedal, my brake lights were still on. I reached -- I totally stopped, reached down, got the cell phone, and she said she had put it on the console and then the wreck occurred. So she's saying I was at a complete stop when the wreck occurred. And what Trooper Lawful found at the scene, the physical evidence supported that, because he found a skid mark about two feet long that ended at her tire, showing that her car had not been moved and that her car at the time of the accident, that was where it was when he saw it. He saw the car where it was immediately after the motorcycle hit it because it's still next to that skid mark.

So when Trooper Lawful comes into court and says there's no problem navigating down that ramp, this car was not an issue, he was testifying based on physical evidence. This was not speculation. And Trooper Lawful, who had investigated a thousand accidents, said he had concluded based on his observations and the smell of alcohol on Mr. Russell, that Mr. Russell's driving while intoxicated was a contributing cause to this accident.

A few other facts. There's no testimony there was any problem with the motorcycle. There was no problem with the exit ramp. The weather was clear that night. Mr. Russell had navigated this exit ramp hundreds, perhaps thousands of times, because that's the ramp he would take

to get to his home. There's no other reason for this accident except inattentiveness and impairment of judgment caused by alcohol, the alcohol that Mr. Russell consumed that evening.

So, Your Honor, based on the receipt, based on the state of the law and our statutes and the absence of South Carolina case law saying that the exclusion must be voided, in the absence of that, and in the presence of the evidence showing that Mr. Russell was intoxicated that evening and that it was the cause of the accident, we would ask that you reconsider the order, that you find that the intoxication exclusion is enforceable and that Mr. Russell's intoxication that evening was in fact a contributing and proximate cause of the accident and therefore renders coverage invalid in this case.

THE COURT: All right. Mr. Moore.

MR. MOORE: May it please, Your Honor, I would respectfully submit that the argument we've heard today is not an appropriate 59E motion to reconsider.

The argument this morning reminds me of that versus of scripture from Ecclesiastes where Solomon says, Too much talk, there is no end. This, too, is a vanity and a chasing at the wind.

We heard these same arguments at the mediation in this case where we were unable to get a realistic

settlement offer.

MR. KRISTINIK: Objection, Your Honor.

THE COURT: Yes.

MR. MOORE: We heard these same arguments at summary judgment. They were denied.

MR. KRISTINIK: Objection, Your Honor. There was no summary judgment in this case.

MR. MOORE: I believe there was an argument. I believe we had a hearing of some sort.

MR. KRISTINIK: Your Honor, I'm not going to interrupt anymore.

MR. MOORE: We had these same arguments at trial. They were denied. We had these same arguments after trial. They were denied. We had these same arguments when we presented the case to His Honor on our proposed orders, and the Court rightfully ruled. And now we're basically here again with the exact same arguments that were urged upon Your Honor at trial and during all of the voluminous documents you have seen post-trial.

We're still trying to settle this case, but we're told we've got to go through this stage before they'll have any legitimate discussions with us.

We have the same arguments we've heard over and over again, and they're just wrong. They're factually wrong. By virtue of public policy, they're more than

wrong. And in truth and equity, they're wrong.

The law is in this case, the law always has been, and the law should remain that a relationship between an insured and its customer is a special relationship. It's a fiduciary relationship. It's not an arm's length transaction. It is one where when a person pays his premiums, he should be entitled to get the coverage that he pays for.

The question in this case is very simple: Can an insurance company deny coverage based on an exclusion in a policy which the carrier has never bothered to give its insured.

Now, it is undisputed in this case that the carrier never delivered the policy of insurance to the insured. The insured says, "I never got it." The agent who sold the first and second coverage said, "We don't have any recollection of ever having received it to have given it to him." And there is no sort of policy procedure, letter of transmittal, nothing, no documentation at all in all of this mound of paper to indicate that the policy of insurance was ever given to the insured.

Now, they talk about this Exhibit 12. The gentleman who testified from the company indicated that that was simply promotional material and was not part of

the policy of the insurance, was not something the insureds rely on, that anybody could rely on. As a matter of fact, if we look at Exhibit 12, it's not even signed by my client, but the testimony was clear from the man who testified from the insurance company, this is simply promotional material and a receipt showing where an initial premium was paid. This is not part of the policy and this is not something that should have been relied on by anybody. Their witness testified to that.

Now, all we ask in that regard is the Court can give meaning to the testimony of their folks. If they say this means nothing, it's no more than a receipt, okay. And, of course, that's all it is is a receipt. Because the public policy of this state is very, very simple. The legislature has said if you're going to sell a person a policy of insurance, you got to give them the policy. It's important that a person be delivered the policy of insurance that he's paying for.

We over and over and over again in our code declare as a matter of statutory public policy that an insurance company with a fiduciary obligation who's going to be taking premiums that somebody's earning, making a living, working, at least has to give them the insurance policy that they're paying for.

Now in this case, the record is undisputed that

my client was never given the policy that he paid for. So the insurance company is attempting to rely upon exclusions in a policy that my client never saw.

Now, our legislature has basically said what happens when you don't get the policy. It says they may not defeat coverage based on a policy if the appropriate delivery is not made. The South Carolina Code 38-71-30, they may not defeat coverage based on a policy exclusion if appropriate delivery is not made.

I cannot for the life of me understand why we have a huge multi-million dollar insurance company who cannot at a minimum give its customers that which it is paying for. But the public policy of our state is well stated in our code, that we expect an insurance company with a fiduciary obligation, when they sell you something they ought at least give it to you. And it's undisputed in this case as the Court has found. There's no evidence at all that they gave it to him, and the only evidence in regard to delivery was that it wasn't delivered.

They didn't even bother to send it to the agent. As a matter of fact, when we came to trial, they couldn't even produce a copy of the policy. The only thing they could produce was what they called a specimen, which they say this is what the policy would have looked like if it ever existed. We don't even have -- in discovery we never

got a copy of the policy. My client was never given a copy of the policy when it was sold to him. And the insurance company doesn't even have a copy of the policy, and there's no indication that the policy was ever even created.

The only place my client's policy remained after he was paying his premiums was apparently in the bowels of the computer where the company came to the conclusion if we ever need it, we'll just go make it. There wasn't ever a policy created in the first place. And that violates the public policy of South Carolina, and that violates the statutory law of South Carolina.

If we look at 38-63-210, which counsel acknowledges applies in this case, it says, "Every insurer doing a life insurance business in the state shall deliver with each policy of insurance issued by it a copy of the application made by the insured so that the whole contract appears in the application and policy of insurance."

They not only didn't deliver the application, they didn't deliver the policy. So there are two things they were obligated to provide, an application as well as a policy. Did they provide either? No.

Then it says, "If the insurer violates the requirements, no defense is allowed to the policy on account of anything contained in, or omitted from, the

application."

If you look at paragraph 12, I guess they take the position that -- I mean Exhibit 12 -- I guess they take the position Exhibit 12 is part of the application. I don't know what they claim it is. They say it's nothing except a receipt for some money and it's not part of the policy. Well, we weren't given the application, we weren't given the policy.

So it says, "If the insurance policy is issued upon an oral application, no defense is allowed to the policy on account of anything contained in, or omitted from, the oral application."

So you have a situation here where the State of South Carolina is basically saying, look, a contract is a contract, and before a person can be bound by an insurance contract -- which we understand we have a special relationship between a carrier and its insured -- you can't use an exclusion unless you've at least given the man a copy of the policy which says it's excluded. You have a situation here where they sold him coverage, they told him he had coverage, they never gave him what he paid for, and then they come back in and attempt to rely on language contained in a specimen policy that was never the policy in the first place.

THE COURT: I thought the testimony of the

specimen policy was that it was -- testimony of never delivery of -- we can't prove delivery of the policy.

MR. MOORE: Right.

THE COURT: Your client said, I wasn't given a policy, so it was consistent.

MR. MOORE: Right.

THE COURT: But what the gentleman that was from out of town that said this is what we normally do, this cover page shows all the different riders and pages that get attached --

MR. MOORE: Right.

THE COURT: -- in a system relating back to the computer where they generate an original, sign it in blue, give it to the insured, and then they keep a letter of all the exclusions that apply to those policies and keep that piece of paper.

MR. MOORE: And he never got that.

THE COURT: But they wouldn't reprint it every time because they didn't want to keep all these policies because they were so voluminous in their vault. They just kept a listing of what the policy would include or exclude.

MR. MOORE: That's exactly right.

THE COURT: I remember that.

MR. MOORE: And what we -- we weren't given

that. We weren't given anything.

THE COURT: All right. I remember that. That's why I --

MR. MOORE: That's why you ruled like you did.

THE COURT: Right. So now, I understand that.

What do I need to reconsider, Mr. Kristinik? I mean, if that's where I stood, what's changed in my reliance on this, I guess, or lack of reliance on this piece of evidence? I mean, it's kind of ball and strike, I call it a strike and you want me to call it a ball. But what else can -- what am I missing?

MR. KRISTINIK: Two things. Address and receipt.

THE COURT: This receipt?

MR. KRISTINIK: That receipt, Exhibit 12. Exhibit 12 says your policy has an intoxication exclusion.

Mr. Moore, he doesn't offer any argument around that other than saying, this is just -- you know, no one pays attention to that, this is just promotional material. Oh, no. No, it is not. Take a look at it.

THE COURT: Didn't their witness say that? Didn't the gentleman --

MR. MOORE: Yes, sir.

THE COURT: The same one --

MR. KRISTINIK: Jack Mackin. I don't remember

Jack Mackin ever saying that this is just promotional material. I cannot imagine he would have ever said that. I'd have to go back and look at the transcript for sure.

THE COURT: Okay.

MR. KRISTINIK: But if he received this and it says exceptions and limitations, your coverage does not cover loss that results from being intoxicated, I mean, what more does one need to know?

THE COURT: I don't remember -- and I'm not saying I remember it not or I remember it yes -- was this given to Russell?

MR. KRISTINIK: Absolutely. Absolutely. And he admitted on the stand -- Gill, the agent, said I gave it to him. And if you look at the affidavit of Mr. Russell, which also is an exhibit in the record, and I don't know the exhibit number off the top of my head, that affidavit, in there he says, I received all the attached documents and one of them was this document.

THE COURT: This was something that was prepared as a result of him bumping up from 2000 to 2500?

MR. KRISTINIK: Correct. That happened in 2002 and the accident happened in, I believe, 2008. So it was absolutely before the accident he is on notice that there's going to be an exclusion in the policy.

MR. MOORE: May I respond to that?

MR. KRISTINIK: Can I finish? Can I finish?

MR. MOORE: I just want to respond to that real quickly because it is sort of an important point.

You know, if you look at -- the original policy was executed in 1999 and then they put more coverage with it in 2002. If you look at this form, it's actually dated, I believe, 2002. So what they're trying to do is to go and say, well, look, the policy's pulled in '99 and all they did was supplement the actual amounts of the coverage. There's nothing that was -- there's nothing we got in '99 that would have been anything like this. And the man did testify that this was not part of the policy.

THE COURT: All right.

MR. MOORE: But that was already considered.

THE COURT: Go ahead.

MR. KRISTINIK: That's number one, the receipt put them on notice.

Number two is, a statute does not require exclusions to be rendered unenforceable. It's very interesting that Mr. Moore appeared to be reading from the statute, 38-71-30, and he read into it that the consequences that you, Your Honor, do not enforce the exclusion. That's not what the statute says. Your Honor needs to definitely look at 38-71-30 and not rely on Mr. Moore's paraphrasing of that statute. And I think it

shows a weakness in the plaintiffs' argument here. They have no law, no case, no statute that allows the Court to rewrite the insurance policy.

Mr. Mackin came in and testified as to what the policy was and Your Honor adopted that testimony in paragraph 16 of your order where you found that yes, the policy in the records of the company, this is it, it's Exhibit 1 offered by the defendants and it has an intoxication exclusion in it. Okay? That's the policy. So what allows the Court to rewrite the policy to eliminate an exclusion? It's not the statute. Absolutely not. The statute tells you what the penalty is for its violation, you can't rely on things in the application. And then there's another provision dealing with the penalties, money or jail time. Nothing talks about rewriting the statute.

There's no South Carolina appellate court case that says you write exclusions out of the policy when there's no delivery. And there's certainly not a South Carolina appellate court case which says you write an exclusion out of the policy even when the insurer is given written notice of the exclusion. Here Mr. Russell was given written notice of the exclusion. He was not -- he suffered no prejudice by this.

Mr. Moore wants to talk about public policy,

it's the public policy to deliver policies? Well, what about the public policy to prevent drinking and driving, a crime that kills hundreds of thousands of people every year? What about the public policy that says someone should not be rewarded for their illegal conduct?

There's no question that Mr. Russell was driving at an intoxication level, a blood alcohol level more than twice that necessary to be prosecuted for DUI. Almost three times that level. What about the public policy that says he should not be rewarded for that?

Your Honor, in conclusion those are the two points. He's on notice and the statute does not mandate the invalidity of the intoxication exclusion.

THE COURT: Okay. Very interesting. Let me read over this. I may be wrong, but I -- these are tough.

MR. KRISTINIK: Your Honor, we've cited several cases in our motion to do with this issue, and if Your Honor would like some guidance, that's a place to turn.

THE COURT: All right. I'll read this. And I won't late as long as I did last time.

MR. MOORE: Thank you, Your Honor, so much.

MR. KRISTINIK: Thank you, Your Honor.

THE COURT: Thank you all.

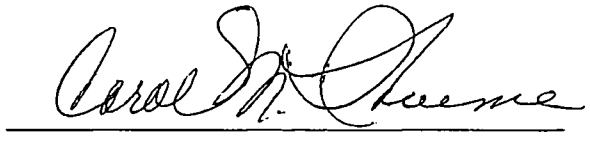
CERTIFICATE OF REPORTER

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)

I, CAROL M. THUEME, RPR, Official Court Reporter for the 11th Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Lexington County, South Carolina, on the 15th day of October, 2013.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

May 31, 2014



CAROL M. THUEME, RPR
Circuit Court Reporter

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.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

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January 12, 2015

THE STATE OF SOUTH CAROLINA
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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that the Record on Appeal complies with Supreme Court Order dated August 13, 2007 regarding personal identifiers and sensitive information.

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