INSTRUCTIONS FOR COMPLETING THE CLAIM FOR DAMAGE FORM

Before filing a Claim for Damage please read these instructions and the Claim for Damage form in its entirety.

Type or print clearly in ink and sign the Claim for Damage form. If you are incapacitated, a minor or a non-resident of the state, a relative, attorney or agent may sign on your behalf.

Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

The following are examples on how to complete the Claim for Damage form:

(1) Doe, John Conner, 12/01/1910

(2) 222 One Way Street, Apt. Z, Seattle, Washington 98178

(3) Post Office Box 111, Seattle, Washington 98178

(4) Same

(5) (206) 555-5555

(6) January 1, 2009, 8:00 a.m.

(7) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item (7).

(8) Washington, Thurston, Tumwater, parking lot of XYZ Cleaners.

(9) I-5, southbound, Milepost, near XYZ Exit.

(10) XYZ Barone Sanitation

(11) Fitzgerald III, Mortamer, 3287 Wonderful Lane, Seattle, Washington 98187, (360)111-1111; tow truck driver, XYZ Towing.

(12) Unknown

(13) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items (11) and (12). Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.

(14) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.

(15) If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.

(16) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include medical records and bills.

(17) Attach documents which support the claim's allegations.

(18) Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss etc. This amount should represent your opinion of total compensation.

(19) If you were injured, please complete the Medicare Verification form (attached).

Mail or Deliver Original Claim to:

Agent to Receive Claim: Manager
District: Petrichor Broadband, LLC
Business Hours: Monday-Friday 7:30 a.m. - 4:30 p.m.

Address: Petrichor Broadband, LLC
302 N Mill Street
Colfax, WA 99111

CLAIM FOR DAMAGE FORM

Under penalty of law, Enduris intends to prosecute all false claims.

CLAIMANT INFORMATION

(1) Claimant's Name: _____,
(Last Name) (First) (Middle) (Date of Birth: mm/dd/yyyy)

(2) Current Residential Address: _____,

(3) Mailing Address (if different): _____,

(4) Residential Address for Six Months Prior to the Date of the Incident (if different from current address):

_____

(5) Claimant's Daytime Phone Numbers: Home Phone # _____, Business/Cell # _____,
Claimant's Email Address: _____

INCIDENT INFORMATION

(6) Date of Incident: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:
From: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)
To: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(8) Location of Incident: _____
(state and county) (city if applicable) (place where occurred)

(9) If the incident occurred on a street or highway: _____
(name of street/highway) (mile post) (at intersection with or nearest intersecting street)

(10) District or agency alleged responsible for damage/injury: _____

(11) Names, address, and telephone numbers of all persons involved in or witness to this incident:

_____

_____

(12) Name, addresses, and telephone numbers of all district or agency employee having knowledge about this incident:

_____

_____

(13) Names, addresses, and telephone numbers of all individuals not already identified in (11) and (12) above that have knowledge regarding the liability issues involved in this incident, or knowledge of the claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

_____

_____

(14) Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

_____

_____

(15) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

(16) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

(17) Please attach documents which support the claim's allegations.

(18) I claim damages in the amount of $_____

(19) If you are injured, are you a Medicare beneficiary? ❑Yes ❑No (check one) If Yes, please complete the Medicare Verification form.

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate # _____ Driver License # _____

Type Auto: _____
(year) (make) (model)

DRIVER:
Address: _____

Phone #: _____

OWNER:
Address: _____

Phone #: _____

PASSENGERS:
Name: _____
Address: _____

Name: _____
Address: _____

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

I, _____, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X _____

X _____
Signature of Claimant(s)

Subscribed and sworn to before me this _____day of _____, 20 ____.

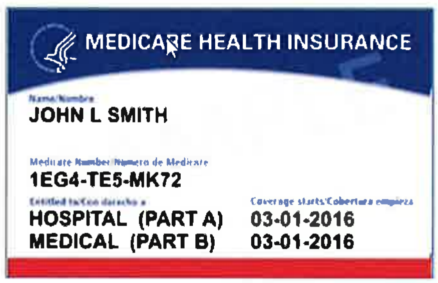
_____
NOTARY PUBLIC in and for the State of Washington

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)** / /	
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex** ☐ Female	☐ Male

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Medicare Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) **Medicare Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**