APPLICATION FOR RETIREMENT INSURANCE BENEFITS

(Do not write in this space)

I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and Part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.

☐ Supplement. If you have already completed an application entitled "APPLICATION FOR WIFE'S OR HUSBAND'S INSURANCE BENEFITS", you need complete only the circled items. All other claimants must complete the entire form.

1.	(a) PRINT your name	FIRST NAME, MIDDLE INITIAL, LAST NAME	Christopher Saint Nick
	(b) Check (X) whether you are	☒ Male	☐ Female
2.	Enter your Social Security number	663-07-33~~89~~	

Answer question 3 if English is not your language preference. Otherwise, go to item 4.

3.	Enter the language you prefer to: Speak	English	Write English
4.	(a) Enter your date of birth	Month, Day, Year	12/25/0000
	(b) Enter name of city and state, or foreign country where you were born.		North Pole, Antarctica
	(c) Was a public record of your birth made before you were age 5?	☐ Yes ☐ No	☒ Unknown
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes ☐ No	☒ Unknown
5.	(a) Are you a U.S. citizen?	☒ Yes *(Go to item 7.)*	☐ No *(Go to item (b).)*
	(b) Are you an alien lawfully present in U.S.?	☐ Yes *(Go to item (c))*	☒ No *(Go to item 6)*
	(c) When were you lawfully admitted to the U.S.?	~~0000~~ 1776	
6.	Enter your full name at birth if different from item 1(a)	FIRST NAME, MIDDLE INITIAL, LAST NAME	
7.	(a) Have you used any other name(s)?	☐ Yes *(Go to item (b).)*	☐ No *(Go to item 8.)*
	(b) Other names(s) used.		
8.	(a) Have you used any other Social Security number(s)?	☒ Yes *(Go to item (b))*	☐ No *(Go to item 9.)*
	(b) Enter Social Security number(s) used.	335-01-7699	

(Over)

Do not answer question 9 if you are one year past full retirement age or older; go to question 10.

9.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions?	☐ Yes ☒ No
	(b) If "Yes", enter the date you became unable to work.	MONTH, DAY, YEAR
10.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security, Supplemental Security Income, or hospital or medical insurance under Medicare?	☐ Yes *(If "Yes," answer (b) and (c).)* ☒ No *(If "No," go to item 11.)* ☐ Unknown *(If "Unknown," go to item 11.)*
	(b) Enter name of person(s) on whose Social Security record you filed other application.	FIRST NAME, MIDDLE INITIAL, LAST NAME
	(c) Enter Social Security number(s) of person named in (b). (If unknown, so indicate.)	
11.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968?	☒ Yes *(If "Yes," answer (b) and (c).)* ☐ No *(If "No," go to item 12.)*
	(b) Enter date(s) of service	Month, Year From: 3/1994 — Month, Year To: 4/1996
	(c) Have you ever been (or will you be) eligible for monthly benefits from a military or civilian Federal agency? (Include Veterans Administration benefits only if you waived Military retirement pay).	☒ Yes ☐ No
12.	Did you or your spouse (or prior spouse) work in the railroad industry for 5 years or more?	☐ Yes ☒ No
13.	(a) Do you (or your spouse) have Social Security credits (for example based on work or residence) under another country's Social Security system?	☐ Yes *(If "Yes," answer (b) and (c).)* ☒ No *(If "No," go to item 14.)*
	(b) List the country(ies):	
	(c) Are you (or your spouse) filing for foreign Social Security benefits?	☐ Yes ☐ No

Answer question 14 only if you were born January 2, 1924, or later. Otherwise go on to question 15.

14.	(a) Are you entitled to, or do you expect to be entitled to, a pension or annuity (or a lump sum in place of a pension or annuity) based on your work after 1956 not covered by Social Security?	☒ Yes *(If "Yes," answer (b) and (c).)* ☐ No *(If "No," go on to item 15.)*	
	(b) I became entitled, or expect to become entitled, beginning	MONTH: March	YEAR: 1997
	(c) I became eligible, or expect to become eligible, beginning	MONTH: March	YEAR: 1955

I agree to promptly notify the Social Security Administration if I become entitled to a pension, an annuity, or a lump sum payment based on my employment not covered by Social Security, or if such pension or annuity stops.

15.	Have you been married?	☑ Yes *(If "Yes," answer item 16.)*	☐ No *(If "No," go to item 17.)*

16. (a) Give the following information about your current marriage. If not currently married, write "None" Go on to item 16(b).

Spouse's name (including maiden name) None	When (Month, day, year)	Where (Name of City and State)
How marriage ended (If still in effect, write "Not Ended.")	When (Month, day, year)	Where (Name of City and State)
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in "Remarks")	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security number (If none or unknown, so indicate)		

(b) Enter information about any other marriage if you:

- Had a marriage that lasted at least 10 years; or
- Had a marriage that ended due to death of your spouse, regardless of duration; or
- Were divorced, remarried the same individual within the year immediately following the year of the divorce, and the combined period of marriage totaled 10 years or more.

Use the "Remarks" space to enter the additional marriage information. If none, write "None." Go on to item 16 (c) if you have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22); and you are divorced from the child's other parent, who is now deceased, and the marriage lasted less than 10 years.

Spouse's name (including maiden name) None	When (Month, day, year)	Where (Name of City and State)
How marriage ended	When (Month, day, year)	Where (Name of City and State)
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in "Remarks")	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security number (If none or unknown, so indicate)		

(c) Enter information about any marriage if you:

- Have a child(ren) who is under age 16 or disabled or handicapped (age 16 or over and disability began before age 22); and
- Were married for less than 10 years to the child's mother or father, who is now deceased; and
- The marriage ended in divorce If none, write "None."

To whom married	When (Month, day, year)	Where (Name of City and State)
How marriage ended	When (Month, day, year)	Where (Name of City and State)
Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in "Remarks")	Spouse's date of birth (or age)	If spouse deceased, give date of death
Spouse's Social Security number (If none or unknown, so indicate)		

Use the 'Remarks' space on page 6 for marriage continuation or explanation.

If your claim for retirement benefits is approved, your children (including adopted children and stepchildren) or dependent grandchildren (including step grandchildren) may be eligible for benefits based on your earnings record.

(Turn to Page 4)

17. List below FULL NAME OF ALL your children (including adopted children, and stepchildren) or dependent grandchildren (including step grandchildren) who are now or were in the past 6 months UNMARRIED and:

- UNDER AGE 18
- AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL OR ELEMENTARY SCHOOL FULL-TIME
- DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22)

Also list any student who is between the ages of 18 to 23 if such student was both: 1. Previously entitled to Social Security benefits on any Social Security record for August 1981; and 2. In full-time attendance at a post-secondary school.

(IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 18.)

None	

18. (a) Did you have wages or self-employment income covered under Social Security in **all** years from 1978 through last year? ☐ Yes *(If "Yes," go to item 19.)* ☐ No *(If "No," answer item (b).)*

(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.

19. Enter below the names and addresses of all the persons, companies, or government agencies for whom you have worked this year, last year, and the year before last. **IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 20.**

NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer.)	Work Began		Work Ended (If still working, show "Not Ended")	
	Month	Year	Month	Year

(If you need more space, use "Remarks".)

20. May we ask your employers for wage information needed to process your claim? ☐ Yes ☐ No

21. THIS ITEM MUST BE COMPLETED, EVEN IF YOU ARE AN EMPLOYEE.
(a) Were you self-employed this year and/or last year? ☐ Yes *(If "Yes," answer (b).)* ☐ No *(If "No," go to item 22.)*

(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business $400 or more? *(Check "Yes" or "No")*
☐ This Year		☐ Yes ☐ No
☐ Last Year		☐ Yes ☐ No

22. (a) How much were your total earnings last year? Amount $

(b) Place an "X" in each block for EACH MONTH of last year in which you did not earn more than *$_____ in wages, and did not perform substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE". If all months were exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Work Affects Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

23. (a) How much do you expect your total earnings to be this year? Amount $ 0

(b) Place an "X" in each block for EACH MONTH of this year in which you did not or will not earn more than *$_____ in wages, and did not or will not perform substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE". If all months are or will be exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Work Affects Your Benefits".

NONE X		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

Answer this item ONLY if you are now in the last 4 months of your taxable year (Sept., Oct., Nov., and Dec., if your taxable year is a calendar year).

24. (a) How much do you expect to earn next year? Amount $

(b) Place an "X" in each block for EACH MONTH of next year in which you do not expect to earn more than *$_____ in wages, and do not expect to perform substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE". If all months are expected to be exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Work Affects Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

25. If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15), enter here the month your fiscal year ends. _____ (Month)

DO NOT ANSWER ITEM 26 IF YOU ARE FULL RETIREMENT AGE AND 6 MONTHS OR OLDER. YOU MAY HAVE MORE FILING OPTIONS; A SOCIAL SECURITY REPRESENTATIVE WILL CONTACT YOU TO DISCUSS ADDITIONAL INFORMATION THAT MAY HELP YOU DECIDE WHEN TO START YOUR BENEFIT. GO TO ITEM 27.

PLEASE READ CAREFULLY THE INFORMATION ON THE BOTTOM OF PAGE 8 AND ANSWER ONE OF THE FOLLOWING ITEMS:

26. (a) ☐ I want benefits beginning with the earliest possible month, and will accept an age-related reduction.

(b) ☐ I am full retirement age (or will be within 12 months), and want benefits beginning with the earliest possible month providing there is no permanent reduction in my ongoing monthly benefits.

(c) ☐ I want benefits beginning with _____.

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, or you are within 3 months of age 65 or older you could automatically receive Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage at age 65. If you live in Puerto Rico or a foreign country, you are not eligible for automatic enrollment in Medicare Part B, and you will need to contact Social Security to request enrollment.

COMPLETE ITEM 27 ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER

Medicare Part B (Medical Insurance) helps cover doctor's services and outpatient care. It also covers some other services that Medicare Part A does not cover, such as some of the services of physical and occupational therapists and some home health care. If you enroll in Medicare Part B, you will have to pay a monthly premium. The amount of your premium will be determined when your coverage begins. In some cases, your premium may be higher based on information about your income we receive from the Internal Revenue Service. Your premiums will be deducted from any monthly Social Security, Railroad Retirement, or Office of Personnel Management benefits you receive. If you do not receive any of these benefits, you will get a letter explaining how to pay your premiums. You will also get a letter if there is any change in the amount of your premium.

You can also enroll in a Medicare prescription drug plan (Part D). To learn more about the Medicare prescription drug plans and when you can enroll, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048). Medicare can also tell you about agencies in your area that can help you choose your prescription drug coverage. The amount of your premium varies based on the prescription drug plan provider. The amount you pay for Part D coverage may be higher than the listed plan premium, based on information about your income we receive from the Internal Revenue Service.

If you have limited income and resources, we encourage you to apply for the Extra Help that is available to assist you with Medicare prescription drug costs. The Extra Help can pay the monthly premiums, annual deductibles, and prescription co-payments. To learn more or apply, please visit www.socialsecurity.gov, call 1-800-772-1213 (TTY 1-800-325-0778) or visit the nearest Social Security office.

27.	Do you want to enroll in Medicare Part B (Medical insurance)?	☐ Yes	☐ No
28.	If you are within 2 months of age 65 or older, blind or disabled, do you want to file for Supplemental Security Income?	☐ Yes	☐ No

REMARKS (You may use this space for any explanations. If you need more space, attach a separate sheet.)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT

SIGNATURE *(First Name, Middle Initial, Last Name) (Write in ink.)*

Date (Month, day, year)	Telephone number(s) at which you may be contacted during the day
03/3/2021	917 333 0097

Direct Deposit Payment Information *(Financial Institution)*

Routing Transit Number	Account Number		
31117996	21173456	☒ Checking ☐ Savings	☒ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route)*
(Enter Residence Address in "Remarks," if different.)

North Pole, Antartica

City and State	ZIP Code	County (if any) in which you now live
North Pole, Antartica	88888	

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness	2. Signature of Witness
Santa Claus	Tony Soprano
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY RETIREMENT INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	**BEFORE** YOU RECEIVE A NOTICE OF AWARD	SSA OFFICE	DATE CLAIM RECEIVED
	AFTER YOU RECEIVE A NOTICE FOF AWARD		

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect your claim, you - or someone for you - should report the change. The changes to be reported are listed on page 8.

Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER
Santa Claus	111-11-3366

Privacy Act Statement
Collection and Use of Information

Sections 202, 205, 223 and 1872 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to make a determination of eligibility for benefits for you and your dependents. We may also share your information for the following purposes, called routine uses:

1. To the Office of Personnel Management (OPM) the fact that a veteran is, or is not, eligible for retirement insurance benefits under the Social Security program for OPM's use in determining a veteran's eligibility for a civil service retirement annuity and the amount of such annuity; and

2. To the Department of State and its agents for administering the Social Security Act in foreign countries through facilities and services to that agency.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0059, entitled Earnings Recording and Self-Employment Income System and 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

CHANGES TO BE REPORTED AND HOW TO REPORT

Failure to report may result in overpayments that must be repaid, and in possible monetary penalties

- You change your mailing address for checks or residence. (*To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.*)
- Your citizenship or immigration status changes.
- You go outside the U.S.A. for 30 consecutive days or longer.
- Any beneficiary dies or becomes unable to handle benefits.
- Work Changes - On your application you told us you expect total earnings for_____to be $_____.
  (Year)

  You ☐(are) ☐(are not) earning wages of more than $_____ a month.

  You ☐(are) ☐(are not) self-employed rendering substantial services in your trade or business.

  (Report AT ONCE if this work pattern changes)
- You are confined to a jail, prison, penal institution or correctional facility for more than 30 continuous days for conviction of a crime, or you are confined for more than 30 continuous days to a public institution by a court order in connection with a crime.
- You have an unsatisfied warrant for more than 30 continuous days for your arrest for a crime or attempted crime that is a felony of flight to avoid prosecution or confinement, escape from custody and flight-escape. In most jurisdictions that do not classify crimes as felonies, this applies to a crime that is punishable by death or imprisonment for a term exceeding one year (regardless of the actual sentence imposed).
- You have an unsatisfied warrant for more than 30 continuous days for a violation of probation or parole under Federal or State law.
- You become entitled to a pension, an annuity, or a lump sum payment based on your employment not covered by Social Security, or if such pension or annuity stops.
- Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.
- Custody Change - Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- Change of Marital Status - Marriage, divorce, annulment of marriage.
- If you become the parent of a child (including an adopted child) after you have filed your claim, let us know about the child so we can decide if the child is eligible for benefits. Failure to report the existence of these children may result in the loss of possible benefits to the child(ren).

HOW TO REPORT

You can make your reports online, by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above change(s) occur, you should report by:

- Visiting the section "my Social Security" at our web site at www.socialsecurity.gov.
- Calling us TOLL FREE at 1-800-772-1213.
- If you are deaf or hearing impaired, calling us TOLL FREE at TTY 1-800-325-0778; or
- Calling, visiting or writing your local Social Security office at the phone number and address shown on your claim receipt.

For general information about Social Security, visit our web site at www.socialsecurity.gov.

For those under full retirement age, the law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law, to adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU ANSWER QUESTION 26.

- If you are under full retirement age, retirement benefits cannot be payable to you for any month before the month in which you file your claim.
- If you are over full retirement age, retirement benefits may be payable to you for some months before the month in which you file this claim.
- If your first month of entitlement is prior to full retirement age, your benefit rate will be reduced. However, if you do not actually receive your full benefit amount for one or more months before full retirement age because benefits are withheld due to your earnings, your benefit will be increased at full retirement age to give credit for this withholding. Thus, your benefit amount at full retirement age will be reduced only if you receive one or more full benefit payments prior to the month you attain full retirement age.
  - Delayed retirement credits may be added to your benefits if you request them to start when you are full retirement age or older.
  - Please visit our www.ssa.gov web site to use the Retirement Estimator to get a personal estimate of how much your benefits will be at different ages. In addition, our web site provides information about other things you should think about when you make your decision about when to begin your benefits.

MEDICAL INSURANCE VERIFICATION FORM

PATIENT INFORMATION

Patient Name: Tony Soprano **Sex**: ☒ Male ☐ Female
Date of Birth: 05/16/1959 **Street Address**: 139 Fathers Ave
City: Patterson **State**: New Jersey **ZIP Code**: 02113
SSN: 113-59-3659 **E-Mail**: mobboss@gmail.com
Home Phone: (917) 333-5674 **Work Phone**: (929) 343-3667
ICD-9-CM Diagnosis Code(s): A6D, 36B, B-4, 36
Anticipated CPT Code(s) for Procedure(s): 74B, 36C

INSURANCE INFORMATION

Insurance Provider: BCBS NJ **Phone**: 911-371-7129
Policy No.: AQT 336675G **Group No.**: 139
Insurance Policy is: ☒ Primary Insurance ☐ Secondary Insurance
Subscriber Name: Tony Soprano **Date of Birth**: 05/16/1959
Subscriber Relationship to Patient: Self

ELIGIBILITY AND BENEFITS

Coverage Start Date: 01/01/1990 **Coverage End Date**: 12/31/1991
Plan Type: ☐ HMO ☒ PPO ☐ Medicare ☐ Other: _____
Deductible: $ 1000 **Has Deductible Been Met?** ☐ Yes ☐ No
Copayment: $ 60 **Coinsurance**: 10 % **Out-of-Pocket Limit**: $ 2000
Benefits: _____

Referral Necessary?..... ☐ Yes ☒ No
Prior Authorization Required?..... ☐ Yes ☒ No
Out-of-Network Coverage?..... ☐ Yes ☒ No

Out-of-Network Financial Responsibilities:

INSURER INFORMATION

Verification Date: 03/16/24 **Verification Time**: 9:00 ☐ a.m. ☐ p.m.
Insurance Rep.: George Stanza **Phone / Ext.**: 917-339-5543
Prior Auth. Phone: 334-569-9173 **Fax**: 311-411-3111
Prior Auth. Contact: Chris Manna **Approval No.**: 3917
Referral Phone: 734-645-8912 **Fax**: 333-799-3819
Referral Contact: _____

Notes:

Has consistent gunshot wounds

Signature: Tony Soprano **Print Name**: Tony Soprano

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