3. NEXT FRIEND, PERSONAL REPRESENTATIVE, OR GUARDIAN INFORMATION
(Fill out this section only if you are submitting this form on behalf of a minor, legally incapacitated, or deceased person)

Is this registration being made by a Next Friend or court-appointed personal representative or guardian on behalf of a minor, legally incapacitated, or deceased person?

If Yes, **complete this section 3.** **YES** ☒ **NO** ☐

Relationship to Registrant
Attach documents proving that you have the relationship to, or the legal appointment for, the Registrant in the box(es) you check. Please review the attached chart that shows the documents you will need to submit.

You must also provide notice to the Registrant's other relatives or court-appointed representatives listed that you are submitting this Registration for the Registrant. For example, if you are the Registrant's sibling, you must notify Registrant's other siblings, parents, aunts, uncles, spouse, children, grandparents, and court-appointed representatives (if any are applicable) that you are registering for the Registrant.

Check all that apply:

- ☐ Spouse
- ☐ Parent
- ☐ Stepparent
- ☐ Adult Child
- ☒ Adult Sibling
- ☐ Adult Aunt
- ☐ Adult Uncle
- ☐ Grandparent
- ☒ Legal Guardian or other court-appointed representative
- ☐ Estate Administrator
- ☐ Other (specify):

Representative's Name	Last: SCOTT	First: DAVID	Middle: R
Representative's Address	Street/P.O. Box: SCHOLOSER ST		Apt./Suite:
	City: WRIGHTSVILLE BEACH	State: NC	Zip: 35678
Representative's Social Security Number	135-78-9222	**Representative's Date of Birth**	9/3/62 (Month/Day/Year)
Date of Death of Registrant (if applicable)	9/1/19 (Month/Day/Year)		

Representative's Contact Information	Phone: 931 737 6254	☐ Work ☒ Mobile ☐ Home
	Alt. Phone:	☐ Work ☐ Mobile ☐ Home
	Email: DAVID@BIGD.COM	

4. ATTORNEY INFORMATION

Did you hire an attorney to represent or assist you?

YES ☒ NO ☐

If Yes, **complete this section 4.**

Attorney's Name	Last MAGIC	First HEATHER	
Firm Name	Law Firm BIG DOG LAW FIRM PLC		
Address	Street BARKY DRIVE		
	City PITBULL	State NJ	Zip 03578
Phone and Email	Phone 555-739-6793	Email CHEW@BITE.COM	

5. DOCUMENT REQUIREMENTS

To register, you must submit the following documents to ARCHER Systems, LLC either in the return envelope provided if you received this form in the mail, or complete the Registration Form and upload the supporting documents by going to the website and following the links at: officialflintwatersettlement.com:

☒	This completed and signed Registration Form and attached Authorization to Disclose Blood Lead Level Test Result Data to MDHHS if Registrant intends to make a personal injury claim. MDHHS Authorization is optional for Registrant to sign. However, such Authorization is the only way that MDHHS can provide Registrant's blood lead level test results to the Settlement Claims Administrator to assist with Registrant's future claim.
☒	Copy of identification document, such as your State-issued ID card, driver's license, birth certificate, tax return or similar document, unless counsel for Registrant/Next Friend signs and verifies this Registration Form with permission of such Registrant/Next Friend.
☒	Any documents required if you filled out section 3 of this form for a minor, legally incapacitated or deceased person.

6. VERIFICATION

I certify and attest under penalty of perjury, pursuant to 28 U.S.C. Section 1746, that: I am 18 years of age or older; the Registrant meets the eligibility criteria above in section 1; all information submitted in support of this Registration, including the information contained within and submitted with this Registration Form, is true, correct, accurate, and complete to the best of my knowledge; and, if I completed section 3 above, I have notified all persons who have the identified relationship with the Registrant and who might qualify to act as a Next Friend for the Registrant, that I am submitting this Registration Form on behalf of the Registrant and none of those individuals have advised me of any objection. I understand that false statements or claims made in connection with this Registration Form may result in fines, imprisonment, and/or any other remedy available by law.

Registrant's or Representative's Signature	DSS		**DATE**	2/11/21 (month) (day) (year)
Printed Name	First DAVID	MI R	Last SCOTT	

Instructions to complete this form are attached.

AUTHORIZATION TO DISCLOSE BLOOD LEAD TEST RESULT DATA:

Michigan Department of Health and Human Services

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's Gender
PAIGE C NELSON			FEMALE
Street Address 62 NOWHERE ST.			Individual's Date of Birth 5/15/99
City PUMP TOWN	State MI	ZIP Code 08935	Phone (721) 973-6795

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION:

The Court Appointed Claims Administrator will keep the test results confidential and will use the information only for purposes of administering the claim and copies of the test results provided will be destroyed when no longer needed by the Claims Administrator.

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

ARCHER Systems, LLC
Name of Person/Organization

1775 Saint James Place, Suite 200
Street Address

Houston, TX 77056
City, State, ZIP Code

(800) 493 - 1754 — Phone Number

( ) — Fax Number

MDHHS WILL SHARE MY BLOOD LEAD TEST RESULTS FOR THE FOLLOWING REASON:

Blood lead test results will be shared with the Court Appointed Claims Administrator to provide proof of blood lead tests for the purpose of making a claim for compensation in the Flint Water Settlement.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- MDHHS Childhood Lead Poisoning Prevention Program will search the blood lead tables based off Name, Date of Birth and Gender provided with this release. The blood lead data tables contain the test result and patient information as reported by the testing facility, unless updated based off of additional resources.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

I WANT ALL THE MONEY

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date
	2/11/21
Name of Individual or Legal Representative DAVID SCOTT	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked: / /	
Signature	Date

COMPLETION: Is voluntary but required if disclosure is requested.

Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.