CONTRACT & POWER OF ATTORNEY

This agreement ("Agreement") is made the 03 day of Aug, 2023, between the following parties: Fiduciary Name (collectively "Client") and **ENVIRONMENTAL LITIGATION GROUP, P.C. ("ELG") and RDP Law Group ("RDP")**, collectively ("Attorney"). In consideration of the mutual promises herein contained, the Parties agree as follows:

PURPOSE OF REPRESENTATION

1.1 Client retains and employs Attorney to represent Client, to investigate and, if appropriate, to file suit for and attempt to recover any damages and compensation to which Client may be entitled against any party or parties responsible for same, as well as attempt to compromise and settle all claims of Client, in connection with or arising out of the events or event that caused the harm to persons or property. Attorney representation DOES NOT include representation for Client's claims related to any self-insured policies, business interruption policies or other collateral source benefits. Furthermore, Attorney will not provide income tax advice relating to the implications of remitting claims for lost income.

ATTORNEY'S FEES

2.1 In consideration of Attorney's services rendered and to be rendered as set out above, Client hereby assigns, grants, and conveys to Attorney the following present undivided interest in the Claims as :

40 % of any settlement or recovery (50% to ELG, 50% to RDP). If no money is recovered for Client, then there will be no attorneys' fee or expense and Client will not owe Attorney a fee or expenses except as otherwise provided herein. However, if Client has previously employed other counsel without disclosing said employment to Attorney who then incurs expenses, Client agrees to reimburse Attorney within 30 days after receipt of a statement for expenses. Also if expenses are incurred on behalf of Client who thereafter employs counsel other than Attorney for this matter, the same will apply. Attorney reserves the right to withdraw if Client refuses the recommendation to settle the case if Attorney determines such settlement to be the best option available. Upon withdrawal, expenses and costs associated with incurred by Attorney on behalf of Client may be reimbursed by Client at the sole discretion of Attorney.

The 40% payable from the settlement or recovery is defined as a contingency fee and is based upon the amount recovered for Client.

2.2 Client understands that the Client is assigning at this time to Attorney the amount stated above as the contingency fee, and that such percentage is of the total recovery or settlement before any costs, expenses, or disbursements are deducted (and Client understands that all costs, expenses, and disbursements are paid out of Client's portion of the recovery, and not out of Attorney's portion).

2.3 If there is any type of settlement whereby Client is to receive or be paid future payments, then the settlement will be reduced to present value, and the settlement will be arranged whereby there will be sufficient cash at the time of the settlement to pay Attorney's contingency fee, which will be based on the present value of the total settlement including the present value of future payments. The present value of the recovery shall be determined by Attorney.

2.4 The interest in the recovery assigned to Attorney is based upon the total amount recovered, and the fact that some portion of the amount recovered may be designated as "attorney fee" by the court or settling party will not limit the compensation to be paid under this Agreement.

APPROVAL NECESSARY FOR SETTLEMENT

3.1 Attorney will not settle the claims without Client's approval. However, Client will not make a settlement or offer of settlement without consulting Attorney.

3.2 Attorney is hereby granted a power of attorney so that it may have full authority to prepare, sign, and file all legal instruments, pleadings, drafts, authorizations, and papers as shall be reasonably necessary to complete representation in this matter, including settlement and/or reducing to possession any and all monies or other things of value due to Client in connection with Client's claims as fully as Client could do in person. Attorney is also authorized and empowered to act as Client's negotiator in any and all settlement negotiations concerning the subject of this Agreement.

3.3 Client hereby authorizes Attorney to negotiate a settlement of Client's claims in whatever manner, and using whatever negotiation strategy Attorney deems appropriate. Client understands and agrees that Attorney may, if appropriate, negotiate a settlement of Client's claim and the claims of other clients similarly situated on an aggregate basis. However, no such settlement will be negotiated without providing Client a description of the claims resolved by

the settlement, the total settlement fund, the amount to be received by Client, and the amount to be received by other clients who are qualified to participate in the settlement, subject to client confidentiality considerations.

3.4 Medicare: Client understands that Medicare regulations may require Attorney to compromise, settle, or execute a release of Medicare's reimbursement claim prior to payment of any amounts recovered for Client. Client further understands that Attorney may be required to undertake a determination of whether such reimbursement claims exist even if they have received no such notice from Medicare prior to any verdict or settlement. Client is responsible for all other liens, subrogation, or claims asserted by third parties.

3.5 CLIENT AGREES TO BE BOUND BY THE TERMS OF ANY BLOCK SETTLEMENTS OR NEGOTIATED SETTLEMENTS REACHED WITH ONE OR MORE DEFENDANTS. CLIENT UNDERSTANDS THAT THE SAID ATTORNEYS WILL NEGOTIATE THE BEST SETTLEMENT POSSIBLE FOR CLIENT AND CLIENT GIVES ATTORNEY BROAD AUTHORITY TO USE ITS JUDGMENT AND DISCRETION IN REACHING A SETTLEMENT. CLIENT AGREES TO COOPERATE FULLY WITH ATTORNEY THROUGHOUT THE ENTIRETY OF THE CASE. FURTHERMORE, CLIENT UNDERSTANDS THAT ATTORNEY MAY WITHDRAW FROM REPRESENTATION IN THE CASE AT ANY TIME, FOR ANY REASON, AT ITS SOLE DISCRETION.

NO GUARANTEE OF RESULTS

4.1 It is understood and agreed that Attorney cannot warrant or guarantee the outcome of Client's case, and Attorney has not represented to Client that Client will recover any damages, compensation, or other payment as a result of Attorney's representation. Client has also been informed that obtaining a judgment or settlement does not guarantee that the opposing parties will be capable of, willing to or actually satisfy the judgment.

SHARING OF EXPENSES

5.1 Attorney often represents a number of clients who were all harmed by the same event or events that caused the harm (referred to herein as "similar injury") to Client or Client's property. The cause of the similar injury is often determined to be the result a few related root causes and therefore it is advantageous to a group of Attorney's clients sharing the similar injury to share costs and expenses benefitting the group of clients.

5.2 Client understands that Attorney may represent numerous other similarly injured clients, and Client agrees that the term "expenses" includes general expenses incurred for the benefit of all such similarly injured clients, including but not limited to retaining and compensating experts, copying documents, postage, research, computerized document management, conference calls, jury consultants, travel, and costs relating to the depositions of parties, witnesses, experts and others. Such common costs and expenses will be allocated equally among all benefited clients on a pro rata basis.

5.3 Direct expenses are those expenses which benefit only Client in Client's individual case. Examples of such direct expenses include, but are not be limited to, payment for Client's medical records and bills, copying of Client's case file, payments to doctors and other health care providers for medical services provided to Client (if any), expert fees associated with determining Client's lost income or property value. Direct expenses will not be shared with any other clients.

5.4 Additionally, there will be the direct expenses which benefit all clients with the similar injury and economically disadvantaged clients, regardless of how they were harmed. Examples of these common expenses include, but are not be limited to, expert depositions, investigative expenses, travel expenses related to prosecuting and litigating this case, general filing fees, mass copying and reproduction costs, and in some instances, mediation fees and trial expenses and payments to experts. Attorney and Client agree that common costs and expenses will be shared by all clients in the group of similarly injured clients pro rata based on the amount of any recovery by an individual client as compared to the total recovery by all of Attorney's clients.

5.5 Attorney may advance, as common costs and expenses, any or all of the court costs and expenses that appear to Attorney to be reasonably necessary for the investigation, preparation, trial, and/or settlement of Client's matter (including attorneys/experts not employed at Environmental Litigation Group, P.C. who assist with resolving any Medicare reimbursement claim). All such costs and expenses advanced or incurred by Attorney shall be deducted from the recovery obtained for Client from Client's portion of recovery. Attorney's contingent fee shall be computed on the total recovery without deduction for costs, expenses, or disbursements.

5.6 As set out hereinabove, Client understands, agrees and acknowledges that common costs and expenses should be shared on a pro rata basis and that Client's share of the common costs and expenses will be deducted from Client's settlement.

COURT COSTS AND EXPENSES

6.1 It is specifically understood and agreed by the parties hereto that all financing expenses such as interest on loans made to finance all reasonable and necessary expenses of Client's case will be paid by Client by deduction from Client's share of the recovery after calculation of Attorney's contingent fee. Said financing expenses shall be deducted from the amounts recovered for Client.

6.2 The terms "court costs" and "expenses" include without limitation: filing fees, costs imposed by courts, expert fees (regarding, without limitation, evaluation, reports, and/or testimony), consultant fees, postage, long distance telephone calls, fax transmissions or receptions, messengers, court reporter fees, record service fees, photocopying, preparation of exhibits and photographs, transportation and/or lodging expenses, court-mandated expenditures, specialized outside

counsel fees and expenses (i.e., probate, taxation, bankruptcy), costs associated with collection of judgments, any expenses of a structured settlement, witness' fees and mileage, medical records, subpoenas, and all other reasonable and necessary costs and expenses which Attorney, in its judgment, determines to be reasonably necessary for the prosecution and/or settlement of Client's claims.

6.3 If Attorney represents Client throughout the course of the litigation and/or settlement negotiation and does not obtain for Client a settlement or recovery, then the Client will not owe Attorney a fee or be required to reimburse any of the above expenses that have been advanced by Attorney except as otherwise provided herein.

COOPERATION OF CLIENT

7.1 Client agrees to cooperate with Attorney at all times. Client further agrees to keep Attorney advised of Client's whereabouts (and provide changes of address and telephone numbers), shall appear on reasonable notice, shall appear for all depositions and court appearances upon reasonable notice, and shall comply with all reasonable requests of Attorney in connection with the preparation and presentation of the aforesaid Claims and causes of action of the Client.

7.2 Attorney may, at its option, withdraw from the case and cease to represent Client should Client fail to comply with any portion of this Agreement, or should Attorney decide for any reason that it cannot continue to represent Client.

7.3 Although the Attorneys have agreed to represent Client in connection with Client's claim(s), Client understands that there are strict statutes of limitation on claims, and that if Client's claims are not filed before the statutes of limitation expire, Client may forever be prevented from bringing a claim. Client understands that Defendants may attempt to dismiss Client's claims based upon those statues of limitations. Client understands the statute of limitation in Client's case may have expired before Client ever contacted the Attorneys, or that the statutes of limitation may expire in the very near future. Client understands and agrees that the Attorneys will not be able to determine whether or not to file a lawsuit on Client's behalf unless and until client has provided (1) definitive proof that Client was exposed to a substance in a manner that could cause injury; and (2) copies of Clients medical records that demonstrate both the date of diagnosis of injury and the first manifestation of injury. Client understands that it will take the Attorneys a minimum of one hundred eighty (180) days after receipt of such information to evaluate Client's case, and that should the statutes of limitations or any other applicable deadlines including but not limited to class registration deadlines, expire prior to or during the aforesaid one hundred eighty (180) day period, Client agrees the Attorneys are not responsible for any consequences related to the expiration of that deadline.

7.4 Client understands and agrees that the Attorneys are under no obligation to file suit should the Attorneys conclude after reasonable investigation that there is no legal basis for commencing an action.

REFERRAL OR ASSOCIATION OF ADDITIONAL COUNSEL

8.1 Client expressly agrees, at the Attorney's discretion, that Attorney associate as co-counsel additional lawyers to assist in effectively representing Client and prosecuting Client's cause of action. The association of additional attorneys will not increase the contingency fee owed by Client to Attorney and the additional or associated attorney will be compensated out of the Attorney's portion of the contingency fee.

8.2 Attorneys employed by Environmental Litigation Group, P.C. are licensed to practice law only in Alabama, District of Columbia, United States Court of Federal Claims, Illinois, Texas and Tennessee.

ALABAMA LAW TO APPLY

9.1 This Agreement shall be governed by and construed in accordance with the laws of the State of Alabama. Attorney and Client agree that, in the event of a dispute among them, the proper venue for resolving the dispute is Jefferson County, Alabama.

DISTRIBUTIONS

10.1 Environmental Litigation Group, P.C. will make all payments solely to the injured party, or Client's personal representative, and will not be responsible for allocating settlement proceeds among heirs or multiple payees.

AGREEMENT VOLUNTARY AND WITH KNOWLEDGE

Client, by signing this Agreement, acknowledges that Client has read and understands said Agreement and enters into it voluntarily.

EXECUTED effective on this 03 **day of** Aug **, 2023.**

CLIENT SIGNATURE: Fiduciary

PRINTED NAME: Fiduciary Name on behalf of Jane Doe Test

SSN: 011-11-1111

WILLIAM H. DURHAM, M.D.
BOARD CERTIFIED INTERNAL MEDICINE
MISSISSIPPI MEDICAL LICENSE #11912
GEORGIA MEDICAL LICENSE #061728

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name Jane Doe Test **Date of Birth** 01/01/1960

Social Security Number 000-00-0000

1. I authorize the use or disclosure of the above named individual's health information as described below. A copy of this authorization may serve in place of the original.

2. The following individual or organization is authorized to make the disclosure:

Name: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

___ Entire record
___ Entire billing record
___ Admissions summary
___ Discharge summary
___ Outpatient/ER Records
___ History & Physical
___ Operative & Procedure reports
___ Test results
___ Pathology reports
___ Laboratory results
___ X-ray (Chest X-ray with 2 views PA/lateral)
___ Consultation reports
___ Other

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatments for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization for the purpose of medical review:

William H. Durham, M.D.
131 Pinehills Drive
Hattiesburg, MS 39402

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6. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: Settlement of Litigation. If I fail to specify an expiration date, event or condition, this authorization will expire in 2 years.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment and payment. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact HIM director, privacy officer, or other office or individual's name or contact information.

8. I have had full opportunity to read and consider the contents of this authorization. I understand that my Health Plan will not condition its payment activities in connection with my claims, or my enrollments in my Health Plan, or my eligibility for benefits upon my giving this authorization.

Signature of Patient or Legal Representative Fiduciary

If signed by Legal Representative, Relationship to Patient spouse

Date Signed _____

Date of Expiration _____

Signature of Witness _____ Date _____

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Spouse Name: _____

Spouse Date of Birth: _____

Spouse Social Security Number: xxx-xx-_____

Address: _____

Phone Number: _____

Do you have any children? Yes _____ No _____

Name	Date of Birth	Address	Phone Number

Please list at least 2 to 3 extended family members or friends who we can leave a message with in case we cannot get a hold of you.

Name	Address	Phone Number

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LAW OFFICES OF
ENVIRONMENTAL
LITIGATION GROUP, P.C.

Gregory A. Cade, MPH, REM
Also licensed in the District of Columbia
United States Court of Federal Claims
Mark L. Rowe (1950-2017)
Kevin B. McKie
Also licensed in the State of Illinois
United States Court of Federal Claims
Gary A. Anderson
United States Court of Federal Claims
Channika DeSilva

PROOF OF REPRESENTATION

The language below should be used when you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. You are not required to use this model language, but proof of representation must include the information provided in this model language. Your representative must also sign that he/she has agreed to represent you. This model language also makes provisions for the information your representative must provide.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information):

( ) Individual other than an Attorney:
(X) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: Gary Anderson, Esq.
Relationship to the Medicare Beneficiary: Attorney
Firm or Company Name: Environmental Litigation Group, P.C.
Address: P. O. Box 550219
Birmingham, Alabama 35255

Telephone: (800) 749-9200

* Note -- If you have an attorney, your attorney may be able to use his/her retainer agreement instead of this language. (If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney etc. will need to submit documentation other than this model language.) Please visit http://go.cms.gov/cobro for further instructions.

Medicare Beneficiary Information and Signature/Date:

Beneficiary's Name (please print exactly as shown on your Medicare card): _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: _____

Beneficiary Signature: Fiduciary _____ Date signed: _____

Representative Signature/Date:

Representative's Signature: _____ Date signed: _____

Street Address:
2160 Highland Avenue South
Birmingham, Alabama 35205

Telephone: (205) 328-9200
Facsimile: (205) 328-9456
Toll Free: 1-800-749-9200
WWW.ELGLAW.COM

Mailing Address:
Post Office Box 550219
Birmingham, Alabama 35255

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OMB No. 3095-0029 Expires 04/30/2024

REQUEST PERTAINING TO MILITARY RECORDS

Requests can be submitted online using eVetRecs at https://www.archives.gov/veterans/military-service-records/

To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH
Doe Test Jane	000-00-0000	01/01/1960	

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE				☐	☐	
b. RESERVE				☐	☐	
c. NATIONAL GUARD				☐	☐	

6. PLEASE LIST LAST FOUR DUTY STATIONS, IF KNOWN: 1. _____ 2. _____ 3. _____ 4. _____

7. IS THIS PERSON DECEASED? ☐ **NO** ☐ **YES** - ***MUST*** *provide Date of Death if veteran is deceased:* _____

8. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ **NO** ☐ **YES**

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent:** Year(s) in which form(s) issued to veteran (Date of Separation): _____
This form contains information used to verify military service. **An UNDELETED DD Form 214 is ordinarily required to determine eligibility for benefits**. If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost. Please note – recent veterans may be able to request a DD Form 214 through milConnect by visiting: https://www.va.gov/records/get-military-service-records/
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☒ **Official Military Personnel File (OMPF):** The OMPF may include duty stations and assignments, training and qualifications, awards and decorations received, disciplinary actions, administrative remarks, enlistment and/or discharge information (including DD Form 214, Report of Separation, or equivalent), and other personnel actions. Detailed information about the veteran's participation in battles and their military engagements is NOT contained in the record.

☐ **Medical Records:** Includes health (outpatient), extended ambulatory, and dental records. If inpatient/hospitalization records are requested, please specify below.
☐ I request inpatient/hospitalization records from _____ (facility), last treated in _____ (year). **(NOTE: Fields are required)**
If available, you may receive copies of inpatient narrative summaries, operative reports, discharge summaries, etc. contained in the record.

☐ **Dental Records:** Please check this box if **ONLY** dental records are needed from the medical record.

☐ **Other (Please Specify):** _____

2. PURPOSE: (Providing information about the purpose of the request is **voluntary;** however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☒ Other (explain)

Explain here: Litigation

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. RELATIONSHIP TO VETERAN: _____

3. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section 1, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN **(MUST submit Proof of Death.** See item 2a on instruction sheet.)

☐ I am the VETERAN'S LEGAL GUARDIAN **(MUST submit copy of Court Appointment)** or AUTHORIZED REPRESENTATIVE (MUST submit copy of Authorization Letter or Power of Attorney)

☐ OTHER (Specify): _____

4. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Maddison Pyles
Name

2160 Highland Ave. S — Suite 200
Street Address — Apt. #

Birmingham — AL — 35205
City — State — ZIP Code

(205) 328-9200 — (205) 328-9456
Daytime Phone — Fax Number

mpyles@elglaw.com
Email Address

5. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section 3 is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on the accompanying instructions sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request is for archival records.)*

Fiduciary

_____ _____
Signature Required – Do not print — **Date**

* This form is available at https://www.archives.gov/veterans-military-service-records/standard-form-180.pdf on the National Archives and Records Administration (NARA) web site. *

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Title	Jane Doe Test - Pfas
File name	PFAS ELG RD...ct 40%.docx and 1 other
Document ID	3637334b3a94e99d1f84252abaa03dfadeab3088
Audit trail date format	MM / DD / YYYY
Status	Signed

Not legally binding. This is a test request.

Document history

SENT	**08 / 03 / 2023** 04:00:53 UTC-7	Sent for signature to Jane Doe Test (prashanth@demandlane.com) from retainers@legalassi.st IP: 3.234.215.139
VIEWED	**08 / 03 / 2023** 04:01:13 UTC-7	Viewed by Jane Doe Test (prashanth@demandlane.com) IP: 193.239.87.27
SIGNED	**08 / 03 / 2023** 04:02:37 UTC-7	Signed by Jane Doe Test (prashanth@demandlane.com) IP: 193.239.87.27
COMPLETED	**08 / 03 / 2023** 04:02:37 UTC-7	The document has been completed.