

UNIVERSITY OF MARYLAND MEDICAL CENTER

- OCCUPATIONAL THERAPY
- PHYSICAL THERAPY
- SPEECH PATHOLOGY/AUDIOLOGY

GIRON, JUSTIN 0172-07-81 M
 STC: 161979 11/23/1965
 ACCT #907191741
 10/19/2009 01:30PM FOL
 O'TOOLE MD, ROBERT V CHP
 410-448-6400 OST UMH
 V# 9071917 SHOCK TRAUMA

Referral Form

Patient's Name Giron, Justin Phone _____
 Diagnosis (R) Scapula + clavicle fx. (L) proximal humerus fx. Date of Birth 11/23/1965
 Precautions/Restrictions _____ Date 10/19/2009

EVALUATE AND TREAT (check if applicable)

Exercise/Testing

- Active ROM
- Active/Assisted ROM B/L UE
- Passive ROM
- Therapeutic Exercise
- Resistive Exercise
- Edema Management
- Ergonomic Training
- Gait Training
- Functional Activities
- ADL Retraining
- Isokinetics
- Home Exercise Program
- Specific Protocol (Provide copy of guidelines)
- Other

Modalities/Procedures

- Iontophoresis/with Dexamethasone
- Ultrasound
- Neuromuscular E-Stim
- Compression Garment
- Sequential Compression Pump
- Continuous Passive Motion
- Traction
 - Cervical
 - Lumbar
- Whirlpool/Wound Care
- Biofeedback
- Other

Special Programs/Other

- Back School/Ergonomic Training
- Cognitive Therapy
- Cumulative Trauma/Education
- Hand/UE Therapy
- Incontinence
- Lymphedema
- Pediatrics
- Pelvic Floor Dysfunction
- Prenatal/Postpartum Rehab.
- Spinal Evaluation
- Splinting/Bracing
- Type: _____

Please Indicate Any Restrictions to the following:

- Active ROM _____
- Passive ROM _____
- Restricted Exercise _____

Weight Bearing Restrictions

	RUE	LUE	RLE	LLE
WBAT	X	X		
PWB				
FFWB				
NWB				

Speech/Audiology

- Hearing Aid
- Hearing Evaluation
- Modified Barium Swallow
- Speech/Language Eval
- Swallowing Eval
- Voice Eval
- Home Program
- Other

Other: ROM, WBAT, & restrictions

Frequency/Duration: 3x/week x 6 weeks

Physician Signature: [Signature]

Physician's Name (print): Mark Vitale Physician's Contact Number: _____

Fax Number: _____

OUTPATIENT LOCATIONS

University of Maryland Medical Center
 22 South Greene Street
 Baltimore, Maryland 21201
 (410) 328-0586
 (410) 328-0847 (Fax)

Frenkil Physical Therapy
 16 S. Eutaw Street, Suite 510
 Baltimore, Maryland 21201
 (410) 328-7725
 (410) 328-2471 (Fax)



DR. O'TOOLE

22C # 101777

MedRec# 1720781

DISABILITY CLAIM FORM

Attending Physician's Statement (page A). Please fully complete this form. If incomplete, we will call for omitted information.

Patient's name JUSTIN GIRON Social security number 451 55 2440 Date of birth 11.23.1965

Physician's name (please print) O'Toole Robert Degree M.D. Specialty Orthopedic

Physician's street address 225 Greene St

City Balto. State or province MD ZIP code 21201

Tax ID number _____ Physician's phone number 410-328-6758 Physician's FAX number 410-328-8827

DIAGNOSIS Left greater tuberosity fracture. @ scapular + clavicle fracture

ICD-9 diagnosis code: 719.90 Blood pressure reading 1 Date of reading _____

Diagnosis (including any complications) _____ Patient's height _____ Patient's weight _____

If disability is due to pregnancy, what is expected or was the delivery date? _____ vaginal delivery caesarean section

Please describe any complications that would extend this disability longer than a normal pregnancy:

Subjective symptoms

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

Is patient ambulatory? house confined? bed confined? hospital confined?

Do you believe the patient is competent to endorse checks and to direct the use of those proceeds? yes no

Is condition due to injury or sickness arising out of patient's employment? yes no

HISTORY

What date did symptoms first appear or accident happen? 8-30-09

Has patient ever had same or similar condition? yes no

If yes, please provide dates and describe past treatment, including any surgical procedures:

NATURE OF TREATMENT (including any type and date of surgery and medications prescribed if applicable) CPT-4 code: _____

Date of first visit 8-30-09 Date of last visit 9-21-09 Date of next visit _____

Frequency of visits weekly monthly other (specify) _____

Has patient been hospitalized? yes no If yes, name and address of hospital and date(s) of confinement:

UMMS Shock Trauma 225 Greene St.

8-30-09 to 9-11-09

CARDIAC (if applicable)

Functional capacity (American Heart Association) class 1 (no limitation) class 2 (slight limitation)

class 3 (marked limitation) class 4 (complete limitation)

METS (circle one) 1 2 3 4 5 6 7

OTHER PHYSICIAN INFORMATION

Was the patient referred to you by, or by you to, another physician? yes no If yes, please provide name and address of other physician:

Physician's name _____ Address _____

Attending Physician's Statement (page B). Please fully complete this form. If incomplete, we will call for omitted information.

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- class 1 - no limitation of functional capacity; capable of heavy work _____ no restrictions (0-10%)
- class 2 - medium manual activity _____ (15-30%)
- class 3 - slight limitation of functional capacity; capable of light work _____ (35-55%)
- class 4 - moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity _____ (60-70%)
- class 5 - severe limitation of functional capacity; incapable of minimal (sedentary) activity _____ (75-100%)

Remarks:

MENTAL/NERVOUS IMPAIRMENT (If applicable)

- class 1 - patient is able to function under stress and engage in interpersonal relations (no limitations)
- class 2 - patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- class 3 - patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- class 4 - patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- class 5 - patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Please define "stress" as it applies to this claimant.

What stress and problems in interpersonal relations has claimant had on the job?

Remarks:

PROGNOSIS

Does the patient's condition restrict employment activities? yes no

If yes, beginning on what date 8/30/09 end date no determined as yet

In an 8 hour day, patient can (restrictions/limitations):

Sitting _____ hrs/day Walking _____ hrs/day Lifting _____ lbs/max Bend/squat _____ hrs/day
 Standing _____ hrs/day Traveling _____ hrs/day Pushing/pulling _____ hrs/day Crawl/climb _____ hrs/day

Explain the specific restrictions and limitations, including any other factors that may affect employment activities:

(L) arm nonweight bearing

When will patient recover sufficiently to return to work:

- 1 month 1-3 months 4-6 months on _____ never

If never, please explain:

REHABILITATION

Can present job be modified to allow the patient to work with impairment? yes no

If yes, please explain: unable to use one arm x 12 weeks & limited use of (R)

Is patient a suitable candidate for medical rehabilitation (i.e. cardiopulmonary program, speech therapy, etc.) yes no

Is patient a suitable candidate for vocational rehabilitation? yes no

If yes, what specific restrictions and limitations would you place on vocational rehabilitation?

Date trial employment could begin? PATIENT'S JOB full-time part-time _____

Date trial employment could begin? ANY OTHER JOB full-time part-time _____

Signature of physician [Signature] Date 10/01/09

This completed form may be faxed to 1-800-255-6609.

Physiotherapy Associates

John Battinelli, PT, MTC, Clinic Director
Timothy J. Chaffman, MPT
Kristy M. Green, MPT
Staci L. Levine, DPT
Sabrina Altama, DPT

Progress Report

To: Dr. O'Toole

Patient: Justin Giron

Diagnosis: Ⓛ ORIF shoulder ; Ⓜ scap/clave fracture

The above patient has been seen 8 times for treatment
 since their initial evaluation on 9/24/09
 since our last communication with you on _____.

Observations:

- Ⓛ FF 155° Ⓜ Full ROM
Act: 140°
ER: 60°
IR: 71°
- pt able to don/doff clothes much easier, grooming/ADLs tolerable \approx min to ϕ pens; mild difficulty w/ restricting and vestless
- A progressing as expected per fbc; will continue \approx ROM \approx Ⓛ as instructed by MD; will begin ARM/PR for MD recommendation for Ⓜ shoulder.
- pain: 3/10 @ rest ; 5/10 @ worst
Takes 1-2 oxycodon per day for sleep
Assessment: oxycodon ~ 1-2 days
- progressing very well; will continue \approx ROM, ARM, PRE per MD recommendation.

In summary, this patient is progressing well with current treatment plan.
 making moderate progress with current treatment plan.
 progressing slowly with current treatment plan.

Recommendations:

- Continue P.T. with current treatment plan for 2-3 neck x 8 neck.
- Change treatment plan to include _____.
- Discharge P.T. with independent home program.
- Hold P.T., pending the results of your evaluation.

PLEASE GIVE PATIENT A P.T. PRESCRIPTION IF FURTHER P.T. DESIRED

Thank you for allowing us to participate in this patient's care. If we can answer any questions regarding their progress, please do not hesitate to contact us at your earliest convenience.

Therapist's Signature [Signature] PT OLF #22212 Date: 10/16/09

8885 Centre Park Drive
Columbia, Maryland 21045
Phone (410) 730-1275, Fax (410) 740-2497

Please call in AM
for appointment
1:30

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DAY OF WEEK:		(M)	T	W	T	F
ARRIVAL TIME:		1:12				
<input checked="" type="checkbox"/>		Patient prepared for doctor visit.				
<input type="checkbox"/>		Patient NOT prepared for doctor visit.				
<input type="checkbox"/>	Late	<input type="checkbox"/>	No Ins Card			
<input type="checkbox"/>	Referral	<input type="checkbox"/>	PFS			
REGISTRATION COMPLETED		TIME: 1:20				
REGISTRATION STAFF		INITIALS: JH				
NURSE:						
TO XRAY:						
TO WAITING "B":						
XRAYS READY:						
TO EXAM ROOM:						

PATIENT WAS GIVEN:	<input type="checkbox"/>	
	<input checked="" type="checkbox"/>	RX for: Meds (P.T) O.T.
	<input type="checkbox"/>	Follow-up Testing
	<input type="checkbox"/>	Work/School Slip
PATIENT'S NEXT APPT SHOULD BE:	<input type="checkbox"/>	1 Week
	<input type="checkbox"/>	2 Weeks
	<input type="checkbox"/>	3 to 4 Weeks
	<input checked="" type="checkbox"/>	5 to 6 Weeks
	<input type="checkbox"/>	Other:

Patient Name: _____

State Farm Insurance Companies



October 29, 2009

Health Operations Center East
P.O. Box 3070
Newark, OH 43058-3070

Justin Giron
7792 Mayfair Circle
Ellicott City, MD 21043-6965

Re: Policy: HOE733113-20
Claim: 20-H0D226176
Loss Date: August 30, 2009

Dear Mr. Giron:

We have received your claim for disability benefits. Our information indicates that your disability will continue beyond your policy's 60-day elimination period. We are unable, however, to determine how long your disability will continue beyond that point.

Please have the enclosed Attending Physician Supplementary Statement claim form completed by your attending physician. Please be sure your physician provides an estimated or actual ending disability date. If there is other pertinent information which you think might help us consider your claim (such as factors which are complicating your disability), we encourage you and your attending physician to use the "Remarks" section of the form.

The form should be returned as soon as possible. If your disability ends in the near future, you may still be eligible for a partial month of disability benefits. Completion of the form will help us determine if benefits can be provided.

If you have any questions, please contact me at the toll free number below. I will be happy to assist you.

Sincerely,

A handwritten signature in black ink that reads "Damaris Carroll".

Damaris Carroll
Health Claim Examiner
Health Insurance Divison
State Farm Automobile Insurance Company
Phone (866) 855-1212
Fax (614) 775-2110

Enclosure

cc: Scalley, 20-9330



State Farm Mutual Automobile Insurance Company

Attending Physician's Supplementary Statement - Accident or Sickness

(The patient is responsible for the completion of this form by his/her physician without expense to State Farm®)

Patient's Name		
Justin Giron	DOB: 11/23/1965	Claim#: 20-H0D226176 FAX: (614) 775-2110 (SXZB)
Nature of sickness or injury.		
Describe any other complications affecting present condition.		
Give dates of treatments (since last report).		
Office Dates		
Hospital Dates		
Is patient still under care for this condition?	If yes, please provide date of next appointment.	If no, please provide date of discharge.
<input type="radio"/> Yes <input type="radio"/> No		
List any diagnostic tests performed since the last report.		
Briefly provide a description of the patient's treatment.		
In your opinion, is the patient able to return to his/her occupation?	If yes, on what date?	If no, when do you anticipate a return to his/her occupation?
<input type="radio"/> Yes <input type="radio"/> No		
Is the patient presently able to function in light or modified duty work?		
<input type="radio"/> Yes <input type="radio"/> No		
What are the patient's restrictions and limitations that prevent full duty work at his/her regular occupation?		
Is the patient consulting any other physicians?		
Doctor(s) Name	Doctor(s) Address	
Doctor(s) Name	Doctor(s) Address	
Remarks		

Physician's Signature _____ Physician's Specialty _____ Date _____

Address _____ City _____ State _____ ZIP Code _____ Phone Number _____

Dr. Orale

Next appointment

11/30/09

1:30 pm

GIRON

Josca Joanne
2091001620
410.328.3684
will complete 1-3 w/Earlene
→ Earlene, fax to boxes

faxed
~~2091001620~~

FACSIMILE TRANSMITTAL SHEET

TO: EARLENE

FROM: JUSTIN 443

GIRON 415

COMPANY: UMMS
STOCK TRAUMA

DATE: ~~9.25.9~~ 4600

10.27.9

FAX NUMBER:
410.328.2893

TOTAL PAGES, INCLUDING COVER: ~~4~~ 3

PHONE NUMBER:
410.328.6280

SENDER'S REFERENCE NUMBER:

STC# 161979

MORTGAGE: ~~DISABILITY~~
DISABILITY PAPERWORK

YOUR REFERENCE NUMBER:

Med Rec# 1720781

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

NOTES/COMMENTS:

EARLENE

Thank you for your help today.

I'm including the Physicians section of my **MORTGAGE** disability insurance paperwork.

Please call me with any questions at 443 415 4600.

Sincerely

Earlene, if possible can you fax back to me at my ~~410.328.3684~~
410.328.3684

Justin Giron Fax 410.950.8625

GIRON

State Farm Mutual Automobile Insurance Company
ATTENDING PHYSICIAN'S STATEMENT

(The patient is responsible for the completion of this form by his or her physician without expense to State Farm Mutual Automobile Insurance Company).

Name of Patient: GIRON JUSTIN Date of Birth 11-23-65
Last First Middle Initial Month Day Year

Policy/Application Number E73311320 Claim Numbers _____

HISTORY

1. Date symptoms first appeared or accident happened: _____
Month Day Year

2. If condition is due to pregnancy, what is the estimated date of conception?
Month Day Year

3. Date patient ceased work due to this condition?
Month Day Year

4. Is this condition due to an injury or sickness arising from the patient's employment?
 Yes No Unknown

5. Has patient ever had same or similar condition?
 Yes No

If yes, state when and describe: (If preferred, records may be submitted)

6. Have you treated this patient for any other condition?
 Yes No

If yes, state when and describe: (If preferred, records may be submitted)

7. Have you completed any other claim forms or are you aware of disability coverage from any other source?
 Yes No

If yes, state name of source:

DIAGNOSIS

8. a. Primary Diagnosis _____
b. Secondary Diagnosis _____
c. Subjective Complaints _____
d. Please provide the results of any objective tests performed: _____
(If preferred, records may be submitted.)

TREATMENT

9. Date patient first consulted you for this condition: _____
Month Day Year

All other dates of treatment: _____

10. Has the patient been hospital confined?
 Yes No

If yes, from _____ through _____
Discharge Diagnosis: _____
Hospital Name: _____
Address: _____

11. Nature of treatment being provided (include surgery and medications, if any): _____

EXTENT OF DISABILITY

12. In your opinion, is/was this patient unable to work at his/her regular occupation due to this condition?

Yes No

If yes, give dates

From _____ To _____
Month Day Year Month Day Year

13. If yes, from the date disability began how long do you expect before this patient will be able to return to his/her regular occupation?

1-3 Months 3-6 Months 6-12 Months More than 12 Months

14. Is/will this patient be able to return to modified duty?

Yes No

If yes, beginning when?

Month Day Year

15. What occupational duties is the patient unable to do?

16. Please provide us with the date of the patient's next appointment for care of this condition.

Month Day Year

REMARKS:

Physician's Name and Address:
(Please print)

Name

Specialty

Address

Phone Number

City State ZIP Code

TIN/Social Security Number

Date

Signature



INSURED'S STATEMENT - DISABILITY CLAIM

State Farm Mutual Automobile Insurance Company
New Albany Health Operations Center
P.O. Box 3070
Newark, OH 43058-3070

Doc Type: 11



Policy/Application Number E733113 20	Claim Number(s)	
Current Lienholder's Name	Address	Loan Number

INSTRUCTIONS FOR SUBMITTING A DISABILITY INSURANCE CLAIM:

- The INSURED'S STATEMENT on the first 2 pages of this form must be completed by the policyholder, and the authorization at the bottom of this page must be signed and dated.
 - The section titled ATTENDING PHYSICIAN'S STATEMENT on the last two pages must be completed by the attending physician.
 - The completed form should be forwarded to the State Farm Health Claims Department at the above address.
- By furnishing this form and other forms for filing proof of loss or by investigating the claim, State Farm shall not be held to admit the validity of any claim or waive the breach of any condition of the policy.

1. Name (last, first, middle initial) GIRON JUSTIN	2. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth 11 23 65	4. Social Security Number 451 55 2480
5. Address (if PO Box, show street address) 7792 MAYFAIR Street EIA MD 21043 City State ZIP Code	6. Telephone Number (include area code) Home 443 415 4600 Work _____ Cellphone _____		

7. Occupation at time of disability ENGINEER	8. Employer's Name and Address PRAXIS ENGR Name Street ANN JEN MD 21049 City State ZIP Code
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9. Is this condition the result of a work-related sickness or injury? Yes No
If yes, provide name and address of the workers' compensation carrier.

10. Nature of Injury or Sickness (Please describe fully. If injury, how and where did accident occur? If sickness, describe symptoms requiring treatment.)

11. When did symptoms first begin or accident happen? Date **8/29/9** Time **1000** A.M. P.M.
(Insured's Statement continued on Page 2)

AUTHORIZATION: I authorize any source having information about me to give to State Farm Mutual Automobile Insurance Company, its contractors, reinsurers, or its representatives all information available within the lesser of ten (10) years or the period specified in my application or policy, as to health history, diagnosis, treatment or prognosis with respect to any physical or mental condition and non-medical information including, but not limited to, employment history, income and other insurance coverage. "Source" includes any doctor, hospital, clinic, U.S. Veteran's Administration (VA) Hospital, mental health facility, or any other medically related facility, insurance company, consumer reporting agency or employer. Any information obtained will be used to determine eligibility for or continuance of insurance or the validity or truthfulness of any claim presented. State Farm Mutual Automobile Insurance Company may release this information to its affiliates, their contractors, reinsurers, representatives, other insurance companies, for their use in connection with insurance transactions or as required by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the Health Insurance Portability and Accountability Act of 1996. However, other applicable state law and protections will still apply.

I understand I may revoke this Authorization by providing written revocation to State Farm Mutual Automobile Insurance Company except to the extent that State Farm Mutual Automobile Insurance Company has taken action in reliance on this authorization.

This authorization is valid for two (2) years from the date of signature and a photocopy is as valid as the original.

The following statement is required on this claim form by law in several states: 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, subject to criminal prosecution and civil penalties.

Insured's Signature _____ Date **10.27.9**
(Insured or Authorized Personal Representative)

12. Have you ever had a similar injury or sickness? Yes No
 If yes, give dates: _____
 If yes, provide name(s) and address(es) of doctor(s) or hospital(s) who provided the previous treatment.

13. Have you ever had the same or similar symptoms? Yes No

14. Date of first treatment by a doctor for this condition: _____
 Name(s) and Address(es) of doctor(s) consulted for this condition: (If others, list on a separate sheet.)

Dr. _____

Dr. _____

Date(s) of treatment: _____

Date(s) of treatment: _____

15. Were you confined to a hospital for this condition? Yes No

Date Admitted: 8/30/9
 Month Day Year

UMD SHOCK TRAUMA
 Hospital Name

Date Discharged: 9/11/9
 Month Day Year

911 GREENE ST
 Address

BMD 20012
 City, State, and ZIP Code

16. I was first unable to work full time: On 8/29/9 10 A.M. P.M.
 Month Day Year Time

17. I returned to work in a limited capacity: On NA To _____
 Month Day Year Month Day Year

18. I was able to return to work full time: On NA
 Month Day Year

19. Please check all applicable benefits:

	Applied For		Receiving	Pending	Denied
	Yes	No			
A. Social Security	<input type="checkbox"/>				
B. Workers' Compensation	<input type="checkbox"/>				
C. State Disability Insurance	<input type="checkbox"/>				
D. Retirement or Pension	<input type="checkbox"/>				
E. Short Term Disability	<input type="checkbox"/>				
F. Salary Continuation	<input type="checkbox"/>				
G. Unemployment	<input type="checkbox"/>				
H. Union	<input type="checkbox"/>				

I. Describe all disability insurance coverage in force, and all disability coverage applied for in the past 12 months. If none, so state by writing "none". NONE

Company or Source	Monthly Amount	Benefit Period

20. Were you a smoker or other tobacco user when this disability began? Yes No



HEALTH INSURANCE

Application for Mortgage Disability Income Policy

01

State Farm Mutual Automobile Insurance Company
Home Office, Bloomington, Illinois 61710

NEW <input checked="" type="checkbox"/>	REINSTATEMENT	BENEFIT CHANGE (EXPLAIN)	POLICY NUMBER E682616
--	---------------	--------------------------	---------------------------------

1. Proposed Insured

LAST NAME GIRON	
FIRST NAME JUSTIN	MIDDLE INITIAL
ADDRESS OF PRINCIPAL RESIDENCE FOR THIS MORTGAGE 7792 MAYFAIR CIR	
ADDRESS OF PRINCIPAL RESIDENCE FOR THIS MORTGAGE	
CITY ELLCOTT CITY	STATE MD
ZIP CODE 21043-3696	COUNTY
SEX M	BIRTH DATE MONTH-DAY-YEAR 11-23-1965
HOME PHONE NUMBER (including area code) 443 415-4600	AGE 42

2.

OCCUPATION AND EXACT DUTIES IT Specialist works inside of an office at a desk- DOES NOT GO OUT OF OFFICE ON SALES CALLS OR TRAVEL.
AVERAGE EARNED INCOME \$ 10,000 PER MONTH
EMPLOYER'S NAME AND ADDRESS <i>Emerje ATs everett, md</i>

3. Coverage

a.	BENEFIT PERIOD 3 YEARS	MONTHLY BENEFIT \$ 1,335	POLICY CHANGE MONTHLY BENEFIT (Show increase amount only) \$	ELIMINATION PERIOD (DAYS) <input type="checkbox"/> 30 <input checked="" type="checkbox"/> 60 <input type="checkbox"/> 90	b.	OCCUPATION CLASS <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 1A <input type="checkbox"/> 2 <input type="checkbox"/> 2B <input type="checkbox"/> 3 <input type="checkbox"/> 4		
	c. MODE (Check One) <input checked="" type="checkbox"/>		SFPP (Monthly) <input checked="" type="checkbox"/>	A		SA	Q	SFPP NUMBER 1074-6901-21

4. a. Are you actively working at the occupation shown as of this date? YES NO
 b. Is this application to cover your home mortgage on your principal residence? YES NO

5. NAME OF FINANCIAL INSTITUTION
TOWER FEDERAL CREDIT UNION

ADDRESS
P O BOX 123

ADDRESS	CITY ANNAPOLIS JUNCTION	STATE MD	ZIP CODE 20701
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MONTHLY MORTGAGE PAYMENT (Monthly amount can include taxes and insurance) \$ 1,340.00	MORTGAGE EFFECTIVE DATE (MONTH - YEAR) 02/2003	MORTGAGE TERM (YEARS) 2033
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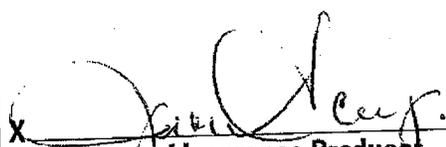
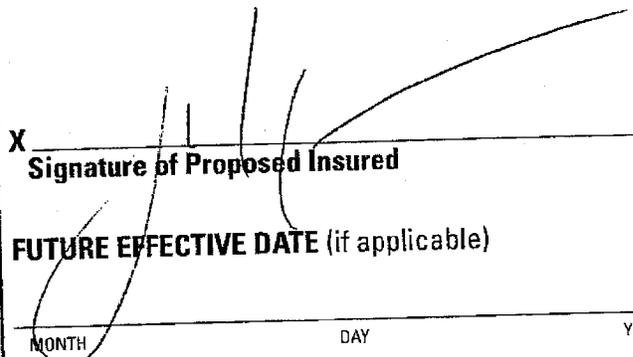
6. Within the past 90 days have you:
 a. had surgery, been scheduled for surgery, or discussed with a medical practitioner the possible need for surgery? YES NO
 b. been admitted, or advised to be admitted, to a medical facility? YES NO

7. a. Are you pregnant? YES NO
- b. Within the past 24 months have you had or been told you had or been treated for heart disease, stroke, liver disease, cancer, or multiple sclerosis?
- c. Within the past 24 months have you been diagnosed, treated, or tested positive for HIV, or been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS)?
- d. Within the past 24 months have you used barbiturates, narcotics, or hallucinogenic drugs not prescribed by a physician, or been treated, counseled, or joined a group because of the use of alcohol or drugs?
- e. During the past 12 months have you been unable to work for more than 20 days in a row due to illness or injury? YES NO
8. Within the last 12 months have you used tobacco in any form? YES NO

PRE-EXISTING CONDITIONS. I understand and agree no benefits are payable for any Total Disability which begins within twelve (12) months from the Policy Date resulting from any injury or sickness which is a Pre-Existing Sickness or Physical Condition.

The answers and statements in this application are true and complete to the best of the applicant's knowledge and belief and the applicant agrees that: (a) no insurance producer has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; and (b) no insurance will be effective unless a policy is issued as applied for and delivered.

THE CONDITIONAL RECEIPT HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT I WILL NOT RECEIVE ANY INSURANCE COVERAGE FOR MY MONEY UNLESS A POLICY IS ISSUED AS APPLIED FOR AND DELIVERED.

<p>All questions on the application have been asked and the information supplied has been truly and accurately recorded. The Conditional Receipt has been explained and given to the Proposed Insured.</p>	<p>Dated on <u>11/22/08</u> <small>MONTH DAY YEAR</small> at <u>Ellicott City, MD</u> <small>CITY STATE</small></p>
<p>X  Signature of Insurance Producer</p>	<p>X  Signature of Proposed Insured</p>
<p>Insurance Producer's Code Stamp</p> <p>J. Scalley 20-9330 FIRE 20 PATUXENT AFO F677</p>	<p>FUTURE EFFECTIVE DATE (if applicable)</p> <p>_____ <small>MONTH DAY YEAR</small></p>
<p>Mailing Address if different from Residence Address:</p> <p>_____</p>	

STATE FARM MUTUAL
AUTOMOBILE INSURANCE COMPANY
Home Office/Bloomington, Illinois

20-9330

INSURED JUSTIN GIRON \$162.80 INITIAL PREMIUM
POLICY NUMBER HE682616 2020
POLICY DATE NOVEMBER 22, 2008 SEMIANNUAL PREMIUM MODE

20071027T326
Sarah
Fax
410.757.8625



HEALTH
INSURANCE

We are pleased to issue this Disability Income Insurance Policy to **you**. It was issued in consideration of **your** application and payment of the required premium.

GUARANTEED RENEWABLE TO AGE 67

If premiums for this policy are paid when due, or within the grace period, **you** have the right to continue this policy in force until **age 67**.

YOUR PREMIUMS MAY BE CHANGED

We may change the table of premium rates for this policy at any time. Any change will apply to all policies in the same class as **yours** in the state where the policy was issued. Any such change shall apply only to premiums due on or after the effective date of change. The amount due on each renewal date will be the renewal premium in **our** table of premium rates for **your** policy in effect at the time of such renewal. **We** will notify **you** in writing at least forty (40) days before the expiration of the grace period applicable to the first such increased premium due on this policy.

THIRTY (30) DAY RIGHT TO EXAMINE POLICY

If **you** feel this policy does not meet **your** insurance need, return it to **us** or **your** insurance producer within thirty (30) days after **you** have received it. **We** will return **your** premium and consider the policy never to have been issued.

IMPORTANT NOTICE

This policy is a legal contract between **us** and **you**. Please review the copy of the application attached to this policy. The application is part of the policy. The policy was issued on the basis that the answers to all the questions and the information shown on the application are correct and complete. Material misstatement or omissions on the application could void the policy. If any information on the application is not correct or is omitted, please immediately contact State Farm Mutual Automobile Insurance Company, Bloomington, Illinois 61710-0001.

Pre-existing condition limitations or exclusions and other limitations or exclusions may apply. Please read your policy carefully.

Countersigned _____
Licensed Insurance Producer

 **JIM SCALLEY, Agent**
6010 University Blvd., Ste.105
Ellicott City, MD 21043
Office (410) 203-9500

MORTGAGE DISABILITY INCOME POLICY

POLICY SCHEDULE

INSURED JUSTIN GIRON \$162.80 INITIAL PREMIUM
 POLICY NUMBER HE682616 2020
 POLICY DATE NOVEMBER 22, 2008 SEMIANNUAL PREMIUM MODE**
 FIRST RENEWAL DATE MAY 22, 2009

 THE BENEFITS AND PREMIUMS SHOWN ON THIS SCHEDULE ARE EFFECTIVE NOVEMBER 22, 2008.

COVERAGE SUMMARY

FORM	COVERAGE INFORMATION	SEMIANNUAL PREMIUM
97055MD	BASIC POLICY - MORTGAGE DISABILITY INCOME	\$162.80
	MONTHLY INCOME FOR TOTAL DISABILITY	
	MONTHLY INCOME AMOUNT	\$1340
	ELIMINATION PERIOD	60 DAYS
	ACCUMULATION PERIOD	120 DAYS
	MAXIMUM BENEFIT PERIOD	36 MONTHS
	NON-TOBACCO DISCOUNT APPLIED	

**PREMIUMS TO BE PAID THROUGH THE STATE FARM PAYMENT PLAN

 SEMIANNUAL RENEWAL PREMIUMS SUBJECT TO RENEWABILITY PROVISION ON PAGE 1
 BASED ON ATTAINED AGE OF INSURED ON EACH RENEWAL DATE

GUIDE TO YOUR MORTGAGE DISABILITY INCOME POLICY
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SECTION 1: IMPORTANT DEFINITIONS

Many words in your policy have specific definitions. We define some words to shorten the policy. Defined words are printed in bold face italics throughout your policy to make it easier to read and understand. This section defines these important terms.

Wherever used in this policy:

Accumulation Period means the number of consecutive days during which the ***elimination period*** must be satisfied. The ***accumulation period*** is shown on the ***policy schedule***, and begins on the first day that ***you*** are ***disabled***.

Age 67 means the first renewal date on or after ***your*** 67th birthday.

Effective Date of Coverage means the date when coverage starts under ***your*** policy and is shown on the ***policy schedule***. Coverage begins at 12:01 A.M. in the area of ***your*** residence.

Elimination Period means the number of days of ***total disability*** which must elapse before benefits become payable for the ***total disability***. These need not be consecutive days of ***total disability***, but must occur within the ***accumulation period*** for the same or related cause. No benefits are payable for the ***elimination period***. ***Your elimination period*** is shown on the ***policy schedule***.

Injury means accidental bodily injury sustained by ***you*** after this policy is in force and shall include all injuries sustained as a result of any one accident. If the ***injury*** occurs before the ***effective date of coverage***, it will be covered under this policy if the loss is incurred or ***disability*** begins after twelve (12) months from the ***effective date of coverage***.

Occupation means ***your*** occupation at the time such ***total disability*** began.

If ***you*** are not working at the time ***your total disability*** begins, ***occupation*** shall then mean any ***occupation*** for which ***you*** are reasonably able to perform by ***your*** education, training or experience.

Physician means a licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which his/her services are performed. The ***physician*** cannot be ***you***, any person related to ***you*** by blood or marriage, a business or professional partner or associate, or any person who has a financial affiliation or business interest with ***you***.

Policy Schedule means the section of ***your*** policy beginning on page 3. It includes important facts regarding ***your*** coverage.

Pre-existing Sickness or Physical Condition means:

1. An ***injury*** or ***sickness*** for which medical advice or treatment was recommended by or received from a ***physician*** within a twenty-four (24) month period preceding the ***effective date of coverage***; or
2. The existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a twenty-four (24) month period preceding the ***effective date of coverage***.

Sickness means any illness or disease first manifesting itself on or after the ***effective date of coverage*** and while this policy is in force and shall include all complications arising therefrom. If the illness or disease manifests before the ***effective date of coverage***, it will be covered under the policy if the loss incurred or ***disability*** begins after twelve (12) months from the ***effective date of coverage***.

Recurrent Disability

If, after the end of a period of **total disability you** again experience a **total disability** while the policy is in force, the later period of **total disability** will be deemed a recurrent disability, which is a continuation of the prior period of **total disability**, unless:

1. **You** have been working for at least thirty (30) hours per week for at least six (6) consecutive months following the end of the preceding period of **total disability**, or
2. The later period of **total disability** is due to a different or unrelated cause.

Such recurrent disability will not be subject to a new **elimination period** or a new **maximum benefit period**.

If either 1. or 2. above applies, the later period of **total disability** will be deemed a new period of **total disability**. A new **elimination period** must be satisfied before benefits start again, and a new **maximum benefit period** will apply.

Concurrent Disability

If a continuous period of **total disability** is caused or is continued by more than one **injury** or **sickness**, it is a concurrent disability. Benefits for a concurrent **total disability** will be paid as if the concurrent **total disability** was caused by one **injury** or one **sickness**. In no event will **you** be considered to have more than one continuous period of **total disability** at the same time.

SECTION 3: EXCLUSIONS AND LIMITATIONS

When We Will Not Provide Benefits

This section describes situations and conditions in which payment will be limited or denied even if **you** otherwise qualify for benefits.

Exclusions

1. This policy does not provide benefits for **total disability** or any other loss caused or contributed to by:
 - (a) Normal pregnancy and childbirth; however, **complications of pregnancy** are covered as a **sickness**;
 - (b) Any attempt at suicide, whether sane or insane, or any intentionally self-inflicted **injury**.
 - (c) War, declared or undeclared, or any act or hazard of war;
 - (d) **Injury** sustained or **sickness** contracted while **you** are in the armed services of any country. The pro-rata unearned premium for any period of such services shall be returned to **you** upon request;
 - (e) **Your** commission of or attempt to commit a felony; or
 - (f) **Injury** or **sickness** which results from **your** being intoxicated or under the influence of any narcotic.
2. **We** will not pay policy benefits for any period **you** are incarcerated.

When Your Claim is Paid

Benefits payable under this policy will be paid immediately upon receipt of proper written proof of such loss.

How Your Claim is Paid

Providing *your* policy is in force, *we* will pay benefits to *you* or *your* estate unless *you* have requested in writing that payment is to be made otherwise. Accrued benefits unpaid at *your* death will be paid to *your* estate.

If benefits are payable to *your* estate, *we* may pay up to \$1,000 to a person related to *you* by blood or marriage whom *we* consider to be entitled to the benefits. Any payments made in good faith will discharge *us* to the extent of the payment.

Change of Beneficiary

The right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

Misstatement of Your Age

If *your* age has been misstated on the application, *your* policy benefits will be based on the amount *your* premium would have purchased at *your* correct age. If *we* would not have issued a policy, *we* will refund the premium *you* paid and consider the policy never to have been issued.

Limitations on Legal Actions

No legal action may be brought to recover on this policy within sixty (60) days after written proof of loss has been given as required by this policy. No such action may be brought after thirty-six (36) months from the time written proof of loss is required to be given.

SECTION 5: PREMIUM PAYMENT AND REINSTATEMENT OF YOUR POLICY

This section discusses issues such as premium payment, importance of paying premiums on time, what happens if premiums are not paid, and protection available in the event of lapse of *your* policy.

Paying Premiums

Premiums are to be paid with United States currency. They are due at the beginning of each policy term. Payment may be made to *us*. *You* can change the policy term if *you* notify *us* in writing and it is agreed upon by *you* and *us*.

Installment Privileges

You may elect to pay any premium due in installments agreed upon by *you* and *us*. Failure to pay any installments when due or within the grace period shall be construed to be a request for cancellation of this policy, effective on the last day of such grace period.

What Happens When Premiums Are Not Paid

You are allowed a thirty-one (31) day grace period. During the grace period, the policy will stay in force. This means that if any premium or installment thereof is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days.

SECTION 6: THE CONTRACT

This section identifies the documents which describe all contractual agreements, the importance of accurate and truthful application completion, and other basic rights, obligations, and features of the policy.

What Makes Up the Contract

The entire contract consists of:

1. The policy;
2. The application;
3. Any endorsements; and
4. Any attachments.

No change in this policy will be effective until approved by one of **our** officers. This approval must be noted on or attached to this policy. No insurance producer may change this policy or waive any of its provisions.

Importance of Information on the Application/Time Limit on Certain Defenses:

1. **Misstatements in the Application.** After twenty-four (24) months from the **policy date** only fraudulent misstatements made by the applicant in the application may be used to void the policy or deny any claim for loss incurred after such twenty-four (24) month period. When benefit limits are increased after the **policy date**, the twenty-four (24) month period for the additional coverage begins on the date the increased benefits became effective.
2. **Pre-existing Conditions.** No claim for loss incurred or disability starting after twelve (12) months from the **effective date of coverage** will be reduced or denied because a **sickness** or physical condition not excluded by name or specific description effective on the date of loss had existed before the **effective date of coverage**. When benefit limits are increased after the **policy date**, the twelve (12) month period for the additional coverage begins on the date the increased benefits became effective.

Your Right to Request Cancellation

You have the right to cancel this policy at any time by written notice delivered or mailed to **us**. Such cancellation will be effective upon receipt or on such later date as **you** state in such notice. **We** may waive these requirements by confirming the date and time of cancellation to **you** in writing. In any event, **we** will return promptly the pro-rata unearned portion of any premium paid. Cancellation shall not prejudice any claim starting prior to the effective date of cancellation.

Conformity with State Statutes

Any provision of this policy which, on the **effective date of coverage**, is in conflict with the statutes of the state in which **you** reside on such date is amended to conform to such statutes.

Assignment

No assignment of interest under this policy shall be binding upon **us** until it is received by **us**. **We** do not assume any responsibility for the validity of an assignment.

