

HOLYOKE SOLDIERS' HOME CLASS ACTION SETTLEMENT
QUESTIONNAIRE

I, the undersigned, am submitting this Questionnaire in support of my request for compensation as part of the Holyoke Soldiers' Home Class Settlement relating to the case captioned as Sniadach et al. v. Walsh et al., 20-CV-30115-MGM. By signing below, I hereby represent, warrant, and certify under the pains and penalties of perjury that the information provided to the Claims Administrator in this Questionnaire and any documentation submitted with the Questionnaire is true, accurate, and authentic.

Date

Signature of Veteran or Veteran's Representative

PROVIDE THE FOLLOWING ADDITIONAL INFORMATION

1.	Name of Veteran:	
2.	Contact Information for the Veteran or Veteran's Representative:	Name: Telephone: E-mail: Fax: Mailing Address: Select preferred method of contact: <div style="text-align: center;">Email Mail Telephone</div>
3.	If you are acting on behalf of a living Veteran, have you been duly appointed as Conservator, Trustee, or Power of Attorney?	Select one: Yes / No If Yes, Please Provide Documentation

Please return by either (1) mailing the Claim Form to Donald K. Stern, Claims Administrator, P.O. Box 961987 Boston, MA 02196, or (2) scanning a legible copy of this form and emailing it to HSHClaims@affiliatedmonitors.com or faxing it to (617) 830-0563.

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4.	If you are acting on behalf of a deceased Veteran, has a court appointed you or someone else as Personal Representative or Executor of the Veteran's Estate?	Select one: Yes / No If Yes, Please Provide Documentation. Note that If you are acting on behalf of a deceased Veteran, a court will have to appoint a Personal Representative of the Veteran's estate prior to the disbursement of any funds.
5.	In addition to filling out this form, do you wish to have the opportunity to speak directly with the Claims Administrator?	Select one: Yes / No
6.	Veteran's Date of Birth	
7.	Veteran's Date of Death	
8.	Veteran's Date of Admission to the Holyoke Soldiers' Home	
9.	Veteran's Surviving Relatives and Relationship to Veteran (Attach Additional Form if necessary)	

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10.	Briefly describe Veteran's medical condition, health, and/or diagnoses prior to March 2020	
11.	Describe the frequency and manner of communications and visits that the Veteran had with family and loved ones prior to March 2020, including the names of people who would visit or communicate with the Veteran, the types of activities that visitors would engage in with the Veteran, whether visitors would take the Veteran off-site for visits, and any other information that you would like the Claims Administrator to consider. (Attach Additional Form if necessary)	

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12.	Describe the severity and duration of the Veteran's pain and suffering after contracting COVID-19, including any details regarding the course of the Veteran's treatment <i>Provide documentation as you think appropriate.</i>	
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13.	Describe any financial support that the Veteran provided to others and that the Veteran would have continued to provide had he or she not contracted COVID-19. <i>Provide documentation as you think appropriate.</i>	
14.	Please provide any additional information or documentation that you wish to share with the Claims Administrator. You may provide the Claims Administrator with statements from loved ones, photographs, medical records, or any other information that you believe will aid the Claims Administrator.	

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Question 9: Additional Information

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Question 11: Additional Information

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