UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

IN RE: ROUNDUP PRODUCTS LIABILITY LITGATION	MDL No. 2741 Case No. 16-md-02741-VC
This document relates to: ALL ACTIONS	

PLAINTIFF FACT SHEET

You are required to provide the following information regarding yourself, or for each individual on whose behalf you are asserting legal claims in the above lawsuit. Each question must be answered in full, but you may approximate where specified below. If you do not know or cannot recall the information needed to answer a question, please explain that in response to the question. Please do not leave any questions unanswered or blank. If you are filling out this Fact Sheet in hard copy, use additional sheets as needed to fully respond.

I. REPRESENTATIVE CAPACITY

A. If you are completing this Fact Sheet **on behalf of someone else** (*e.g.*, a deceased person, an incapacitated person, or a minor), please complete the following:

1. _____
Your Name

2. _____
Your Home Address

3. What is your relationship to the person upon whose behalf you have completed this Fact Sheet? (*e.g.*, parent, guardian, Estate Administrator)

_____

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used or was exposed to Roundup® or other glyphosate-based herbicides.]

II. PERSONAL INFORMATION

A. Name: _____

Other Names by which you have been known (from prior marriages or otherwise, if any): _____

B. Sex: _____

C. Social Security Number: _____

D. Date and Place of Birth (City, State, Country):

_____

E. For each different city where you have lived for the past twenty-five (25) years, provide the following information:

City and State (include Country if outside the United States)	**Approximate Dates You Lived There (Month/Year to Month/Year)**

F. Please complete the chart below detailing your employment history for the past twenty-five (25) years. If there were periods of retirement, unemployment, or student status during the past 25 years, include those as well.

Number	Name of Employer	City and State Where You Worked	Approximate Dates of Employment (Month/Year to Month/Year)	Occupation or Job Title	Job Duties
1					
2					
3					
4					

G. Workplace Checklist: Have you ever worked in any of the occupations or workplaces listed below? If so, please check "yes" and then list the number(s) in the chart in section II(F) above that corresponds to that occupation.

Industry	Yes	No	Number in Chart in Section II(F)
Car Mechanic			
Cleaning/Maid Service			
Electrician			
Farming/agricultural			
Hairdressing			
Handled fission products			
Handled jet propellant			
Handled solvents			
Horticultural			
Hospitals and Clinics			
Landscaping			
Metal Working			
Painting			
Pest Exterminator			
Pesticide use			
Petroleum Refinery			
Rubber Factory			
Schoolteacher			
Textile			
Woodworking			
X-radiation or gamma-radiation (regular exposure)			

III. FAMILY INFORMATION

A. For any grandparent, parent, sibling, or child who has been diagnosed with cancer or who has died, please provide the following information. Please include any adopted or step-children or siblings.

Name	Relationship	Approximate Birth Year	Approximate Date of Death	Cause of Death	Diagnosed with cancer?	Date/Type

IV. PERSONAL MEDICAL HISTORY

A. To the best of your ability, please list all primary care healthcare providers (not including pharmacies) where you have received care over the last 25 years. For each, please provide the name, city and state, and approximate dates of care.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

B. Please indicate whether your medical history includes any of the following conditions, procedures, or medications:

Condition, Procedure, or Medication:	**Yes**	**No**	**Treating Physician**
Diabetes			
Obesity			
Auto-immune diseases (including but not limited to Crohn's disease, Ulcerative Colitis, HIV)			
Epstein Barr			
Ulcers			
Celiac Disease			
Hepatitis C			
Eczema			
Radiation			
Smoking			
Lupus			
Rheumatoid Arthritis			
Organ, stem cell, or other transplant			
Immunosuppressive Medications			

C. To the best of your ability, please list all healthcare providers (not including pharmacies) where you have received treatment over the last 25 years for any type of cancer (including NHL), **or** for any of the conditions, procedures, or medications listed in the chart directly above. For each, please provide the name, city and state, approximate dates of care, and the reason for your visit. You do not need to repeat healthcare providers listed in question (A). **Please also execute the medical authorizations included in Exhibit A.**

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

V. CANCER HISTORY

A. Have you been diagnosed with non-Hodgkin's lymphoma, or "NHL"?

Yes _____ No _____

B. When were you first diagnosed with NHL?

Year _____ Month _____

C. Approximately when did you first begin experiencing symptoms of NHL?

Year _____ Month _____

D. Please list the names of the physician(s) that first diagnosed you with NHL and the city and state in which you were diagnosed.

_____

E. Please list the names of the primary oncologist(s) who have treated your NHL.

_____

F. Describe your NHL. For example, do you have B-cell or T-cell NHL? Is it aggressive or indolent? Small cell or large cell? Any other details? (If you have Mycosis Fungoides, make sure to specify this.)

_____

G. Have you been diagnosed with any types of cancer other than NHL?

Yes _____ No _____

H. **If yes**, please answer the following questions for each type of cancer that you have been diagnosed with other than NHL:

1. What type of cancer was diagnosed (including sub-type, if applicable)?

_____

2. On approximately what date did you first experience any symptoms that you believe are related to that cancer?

_____

3. Please list the names of the physician(s) that first diagnosed you with that cancer.

_____

4. Please list the names of the primary oncologist(s) who have treated that cancer.

_____

I. Has any physician or healthcare provider ever told you that you have a genetic predisposition for developing NHL or other types of cancer?

If yes, answer the following:

1. Name, location (city and state), and occupation of the person who told you this.

_____

2. What were you specifically told about your genetic predisposition?

_____

_____

_____

3. Approximately when were you told this information?

_____

VI. PRIOR CLAIMS, LEGAL MATTERS, AND MEDICAL COVERAGE

A. Have you ever filed a workers' compensation claim for accidents or injuries relating to substance exposure in the workplace? (Answer "no" if you have only filed workers' compensation claims **unrelated to** substance exposure.)

Yes _____ No _____

If yes, please state:

1. Approximate date the claim was filed with your employer, or date that you notified employer of accident/injury giving rise to workers' compensation claim:

_____

2. Nature of injury or accident claimed (what happened):

_____

_____

_____

B. Have you ever filed a claim for Social Security disability insurance benefits ("SSDI") for a disability caused by substance exposure in the workplace? (Answer "no" if you have only filed SSDI claims **unrelated to** substance exposure.)

Yes _____ No _____

If yes, please state:

1. Approximate date the claim was filed with the Social Security Administration:

_____

2. Nature of disability giving rise to claim:

_____

_____

_____

C. Have you ever filed any other type of disability claim for a disability caused by substance exposure in the workplace? (Answer "no" if you have only filed other types of disability claims **unrelated to** substance exposure.)

Yes _____ No _____

If yes, please state:

1. Approximate date claim was filed: _____

2. Name of insurer/employer/government or other party to whom claim was made and, if applicable, claim number assigned:

_____

_____

_____

3. Nature of disability giving rise to claim:

_____

_____

D. Have you ever been denied life insurance for reasons relating to your medical, physical, psychiatric or emotional condition?

Yes _____ No _____

If yes, please state when, the name of the company, and the reason(s) for denial.

_____

_____

_____

E. Have you ever been denied medical insurance?

Yes _____ No _____

If yes, please state when, the name of the company, and the reason(s) for denial.

_____

_____

_____

F. Have you ever **filed** a lawsuit or claim (**including administrative charges, unemployment claims, and bankruptcy petitions)** against anyone aside from the present lawsuit?

Yes _____ No _____

If yes, for each lawsuit, state (1) the court in which the lawsuit was filed; (2) the case name; (3) the civil action or docket number assigned to the lawsuit; (4) a description of your claims in the lawsuit; and (5) the final result, outcome, or adjudication of claims (*e.g.*, whether the lawsuit was dismissed by parties, dismissed by court, judgment granted in favor of a party).

_____

_____

_____

_____

VII. ROUNDUP® AND OTHER GLYPHOSATE-BASED HERBICIDES

A. Have you used Roundup® or other glyphosate-based products?

Yes _____ No _____

B. When did you first begin using Roundup® or other glyphosate-based products?

Year _____ Month _____

C. Please complete the chart below to detail your exposure to Roundup® and other glyphosate-based products. Use as many rows as necessary to describe different periods of usage.

Dates of Usage	**Product Name (Please specify which products are Roundup® products.)**	**Frequency of Exposure**	**Usage**	**Type of Usage**[1] (check all that apply):	**Reason for Usage**	**Location of Exposure (City and State)**
Example: 1980-1985	Example: Roundup® Grass and Weed Killer	Example: Once per week	Example: I sprayed Roundup® in my yard using a hand sprayer.	Residential: _X_ IT&O: ___ Agricultural: ___	Example: To control weeds on my personal property.	Example: Oakland, CA
				Residential: ___ IT&O: ___ Agricultural: ___		
				Residential: ___ IT&O: ___ Agricultural: ___		
				Residential: ___ IT&O: ___ Agricultural: ___		

[1] Residential includes using the product on your lawn, garden, or place of residence. Industrial, Turf, and Ornamental ("IT&O") includes using the product in areas such as golf courses, nurseries, roadsides, or for turf management or landscaping. Agricultural includes using the product to assist with farming or harvesting crops.

D. Describe any precautions you took while using these products (examples: wearing gloves, a mask, or other protective gear).

_____

_____

_____

E. For the products identified in the chart above, do you have the receipts, proof of purchase, or store of purchase for each product you claim to have used?

Yes _____ No ____

To the extent you have receipts, proof of purchase, or store of purchase for these products, please provide copies of those receipts and other documents.

F. Please complete the chart below to detail your exposure to other herbicides or pesticides. Use as many rows as necessary to detail different periods of usage.

Dates of Usage	Type and Brand of Herbicide or Pesticide	Frequency of Exposure	Usage	Reason for Usage
Example: 2000-2010	Example: Viper Insecticide Concentrate	Example: every weekday	Example: I sprayed it using a pump sprayer.	Example: I used the pesticide in my job as an exterminator.

VIII. DAMAGES CLAIMS

A. If you are claiming loss of income due to injuries allegedly caused by Roundup® or other glyphosate-based herbicides, complete the following for each of your employers, starting ten (10) years prior to your first diagnosis with cancer (whether NHL or another type of cancer) and continuing through today.

Employer	Location (City and State)	Average Hours per Week	Day or Night Shift	Approximate Dates of Employment	How much money did you make in this job per week? Please specify how much was due to overtime pay or bonuses.

B. State the total amount of time that you have lost from work as a result of any medical condition that you claim was caused by Roundup® or other Monsanto glyphosate-based herbicides, and the amount of income that you lost:

1. Medical Condition: _____

2. Total number of days lost from work due to above medical condition or, if forced retirement, date of retirement:

_____days

3. Estimated total income lost (to date) from missed work, including

explanation as to method used to calculate number:

_____

_____

_____

C. Have you paid or incurred any out-of-pocket medical expenses (that is, expenses not paid by your insurance company or by a government health program) related to any condition that you claim or believe was caused by Roundup® or other Monsanto glyphosate-based products for which you seek recovery in this lawsuit?

Yes _____ No _____

If yes, please state the total amount of such expenses at this time: $ _____

D. If you are making any claims for other non-medical out-of-pocket expenses, please complete the following:

1. For what? _____

2. Amount of fees or expenses: $ _____

E. Please list the names of all insurers or government health programs who have been billed for or paid medical expenses related to any condition that you claim or believe was caused by Roundup® or other Monsanto glyphosate-based products for which you seek recovery in this lawsuit.

_____

_____

_____

IX. DOCUMENTS

Please attach the following documents to this Fact Sheet, making certain that all releases are signed and dated within **30** days of submission:

A. Medical records release (Ex. A)—execute one per healthcare provider (including mental health, only if you are claiming mental health damages, including emotional distress, in the lawsuit). Plaintiffs' counsel will also obtain 10 blank forms covering the past 25 years, and if Monsanto identifies additional health care providers not identified in the PFS or on Exhibit A, Plaintiff will fill in that health care provider and provide to Monsanto within seven days of the request.

B. Employment history release (Ex. B)—execute one for each employer in the past 25 years.

C. Workers' compensation, social security disability, and insurance claims releases (Ex. C).

D. If you are claiming loss of income due to injuries allegedly caused by Roundup® or other glyphosate-based herbicides, complete the tax records and social security income release for the past 10 years (Ex. D).

E. If applicable, decedent's death certificate.

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge, information and belief, and that I have supplied all the documents requested in Part IX of this Declaration, to the extent that such documents are in my possession, custody, or control, or in the possession of my lawyers.

_____ _____

Signature Date

_____

Name (Printed)

Exhibit A

_____
Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Pursuant to the **Health Information Portability and Accountability Act (HIPAA) Privacy Regulations,** 45 CFR § 164.508, you are hereby authorized to release my entire medical records file to the Records Requester listed below. This release authorizes you to furnish copies of all medical records, including but not limited to medical history or examination reports and notes, laboratory reports, pathology slides, reports, notes and specimens, radiographic films, CT scans, X-rays, MRI films, MRA films, correspondence, progress notes, prescription records, echocardiographic recordings, written statements, employment records, wage records, insurance, Medicare, Medicaid and disability records, and medical bills regarding my injuries, diseases, diagnoses, or treatment, specifically including but not limited to cancer diagnoses and treatment. This authorization ***does not extend*** to psychotherapy notes, as that term is defined in the HIPAA Privacy Rules, 45 C.F.R. §164.501, to mean notes recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during private, joint or group counseling sessions, and which are kept separate from my medical records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above and no other purpose. You are hereby authorized to release these medical records to the following Records Requester for their use in the above-entitled litigation. Monsanto Company ("Monsanto"), a defendant in the above lawsuit, has agreed to pay reasonable charges to supply copies of such records. Copies of any records obtained will be

provided, per agreement, to my legal counsel. You should provide all documents and information to:

Records Requester

1. ATTN: Mr. Gregory Chernack, HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any member, associate or designee of the law firm.

I understand that the health information being used/disclosed may include information and/or records relating to and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases and drug and alcohol use.

I understand that this authorization pertains only to the civil litigation referenced above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. I understand that this authorization remains in full force and effect until such expiration or revocation, as more fully described below, and further authorizes you to release to the Records Requester any additional records created or obtained by you after the date of execution of this authorization. I understand and intend that you may rely on this authorization in all respects unless you have previously been advised by me in writing to the contrary.

I understand that I may revoke this authorization at any time by providing you a written revocation, but that my revocation will be effective only to the extent that the information has not already been released. I further understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.

I understand that any documents or information released by you could potentially be re-disclosed by the aforementioned Records Requester and that any information re-disclosed by that party is not subject to this authorization. I expressly permit the Records Requester to re-disclose my medical records file for purposes limited only to this civil litigation matter and only to the extent necessary and further limited to medical-related consultants and/or experts of the Records Requester or related to Monsanto's obligations to provide information to any federal or state authorities if required by law. I grant this permission only on the condition that the Records Requester mark each and every page of my records with a stamp designating them as "Confidential."

This authorization shall not be valid unless the Records Requester named above has executed the acknowledgment at the end of this authorization.

This authorization is executed and served in compliance with HIPAA, the Federal Regulations promulgated thereunder, and more specifically, 45 C.F.R. § 164.508, all of which govern the requirements for the release of private health information.

Name of Patient	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's Authority to Act for Patient.

ACKNOWLEDGMENT

The undersigned, as the Records Requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records and information from the person or entity to whom it is addressed. The attorney for or the person named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requester at a reasonable cost.

Date: _____

Records Requester's Signature: _____

_____
Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

In Compliance With the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

Pursuant to the **Health Information Portability and Accountability Act (HIPAA) Privacy Regulations,** 45 CFR § 164.508, you are hereby authorized to release my entire medical records file to the Records Requester listed below. This release authorizes you to furnish copies of any information, including but not limited to medical records, psychotherapy notes, and clinical information concerning the assessment, evaluation, treatment, and/or hospitalization related to mental health or psychiatric illnesses or conditions.

This authorization is being given at my request in conjunction with the civil litigation matter listed above and no other purpose. You are hereby authorized to release these medical records to the following Records Requester for their use in the above-entitled litigation. The defendant in the above lawsuit has agreed to pay reasonable charges to supply copies of such records. Copies of any records obtained will be provided, per agreement, to my legal counsel. You should provide all documents and information to:

Records Requester

1. ATTN: Mr. Gregory Chernack, HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any member, associate or designee of the law firm.

I understand that the health information being disclosed by these psychotherapy notes may include information relating to and treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases and drug and alcohol use.

I understand that this authorization pertains only to the civil litigation referenced above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. I understand that this authorization remains in full force and effect until such expiration or revocation, as more fully described below, and further authorizes you to release to the Records Requester any additional records created or obtained by you after the date of execution of this authorization. I understand and intend that you may rely on this authorization in all respects unless you have previously been advised by me in writing to the contrary.

I understand that I may revoke this authorization at any time by providing you a written revocation, but that my revocation will be effective only to the extent that the information has not already been released. I further understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

I understand that any documents or information released by you could potentially be re-disclosed by the aforementioned Records Requester and that any information re-disclosed by that party is not subject to this authorization and may not be subject to HIPAA, the Federal Regulations promulgated under the authority of HIPAA, and more specifically, the requirements imposed by 45 C.F.R. § 164.508. I expressly permit the Records Requester to re-disclose my medical records file for purposes limited to this civil litigation matter or related to the defendant's legal obligations to provide information to the Environmental Protection Agency.

This authorization shall not be valid unless the Records Requester named above has executed the acknowledgment at the end of this authorization.

This authorization is executed and served in compliance with HIPAA, the Federal Regulations promulgated thereunder, and more specifically, 45 C.F.R. § 164.508, all of which govern the requirements for the release of private health information.

Name of Patient	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's Authority to Act for Patient

ACKNOWLEDGMENT

The undersigned, as the Records Requester named in the above medical authorization, hereby declares under penalty of perjury, pursuant to 28 U.S.C. § 1746, that the attorney for the patient named in the foregoing medical authorization has been given notice that the authorization will be used to request records and information from the person or entity to whom it is addressed. The attorney for or the person named in the foregoing medical authorization has also been afforded an opportunity to order copies of the records requested from the undersigned requester at a reasonable cost.

Date: _____

Records Requester's Signature: _____

Exhibit B

_____
Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the firm of HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any other member, associate or designee of the firm, to be furnished copies of my entire personnel file, including but not limited to documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. The defendant in the above lawsuit has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final judicial order, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name of Employee /Former Employee	Signature	Date of Birth	Date Signed

Exhibit C

_____
Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF WORKERS' COMPENSATION RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any member, associate or designee of the firm to be furnished copies of my entire workers' compensation file, including but not limited to any claims made by me, and any documents discussing, describing, or explaining the investigation and processing of that claim and all other pertinent documents, including all medical records and memoranda. Monsanto Company ("Monsanto"), a defendant in the above lawsuit, has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other financial judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's Authority to Act.

Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any member, associate, or designee of the firm to be furnished copies of my entire insurance file, including but not limited to any and all health insurance questionnaires, claims made by or against me, and any documents discussing, describing, or explaining the investigation and processing of that claim and all other pertinent documents, including all medical records or memoranda. Monsanto Company ("Monsanto"), a defendant in the above lawsuit, has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judgment order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name of Insured	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's Authority to Act for Insured

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

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 3 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 1-800-772-1213 (TYY 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.***

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
The Marker Group, Inc.	13105 Northwest Freeway, Suite 300, Houston, TX 77040

***I want this information released because:** Litigation

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. [X] Verification of Social Security Number
2. [X] Current monthly Social Security benefit amount
3. [X] Current monthly Supplemental Security Income payment amount
4. [X] My benefit or payment amounts from date 2008 to date 2017
5. [X] My Medicare entitlement from date 2008 to date 2017
6. [X] Medical records from my claims folder(s) from date 2008 to date 2017

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [ ] Complete medical records from my claims folder(s)
8. [X] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   SSA Form under other records: Assessments; Questionnaires; Applications for Claims; DDS Determinations; Award or Denial Letters; SSA form 821; SSA form 3368

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Exhibit D

Form **SSA-7050-F4** (10-2016) UF
Discontinue prior editions
Social Security Administration

OMB No. 0960-0525

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information
Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings
Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are FREE to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Privacy Act Statement
Collection and Use of Personal Information

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224).
In addition, you may choose to pay for the earnings information you requested with a credit card.
31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to:
(1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717 and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government.
A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

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 only comments relating to our time estimate above to:*** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name: Middle Initial:

Last Name:

Social Security Number (SSN) - - One SSN per request

Date of Birth: / / Date of Death: / /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

[X] **Itemized Statement of Earnings $115**
(Includes the names and addresses of employers)
If you check this box, tell us why you need this information below.

Litigation

Year(s) Requested: 2008 to 2017
Year(s) Requested: to

[ ] Check this box if you want the earnings information **CERTIFIED** for an additional $33.00 fee.

[ ] **Certified Yearly Totals of Earnings $33**
(Does not include the names and addresses of employers)
Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

Year(s) Requested: to
Year(s) Requested: to

3. If you would like this information **sent to someone else**, please fill in the information below.
I authorize the Social Security Administration to release the earnings information to:

Name The Marker Group, Inc.

Address 13105 NW Freeway, Suite 300 State TX

City Houston ZIP Code 77040

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

Signature AND Printed Name of Individual or Legal Guardian

SSA must receive this form within 120 days from the date signed

Date / /

Relationship (if applicable, you must attach proof) Daytime Phone:

Address State

City ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address *(Number and Street, City, State and ZIP Code)*	Address *(Number and Street, City, State and ZIP Code)*

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for **only ONE** Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form. Tell us the specific years of earnings you want, type of earnings record, and provide your mailing address. The itemized statement of earnings will be mailed to ONE address, therefore, if you want the statement sent to someone other than yourself, provide their address in section 3. Mail the completed form to SSA within 120 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided. Select **ONE** type of earnings statement and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings
This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings
This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attach the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings
The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings
You can request earnings information from the record of a deceased person if you are:
- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a $115 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings
In most instances, individuals request Itemized Statements of Earnings for purposes unrelated to our programs such as a private pension plan or personal injury suit. Bulk submitters may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional $33.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings
We charge $33 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment
This Fee Is Not Refundable. DO NOT SEND CASH.

You may pay by credit card, check or money order.
- Credit Card Instructions
  Complete the credit card section on page 4 and return it with your request form.

- Check or Money Order Instructions
  Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

- **Where do I send my complete request?**

Mail the completed form, supporting documentation, and applicable fee to: **Social Security Administration** Division of Earnings and Business Services P.O. Box 33011 Baltimore, Maryland 21290-3003	If using private contractor such as FedEx mail form, supporting documentation and applicable fee to: **Social Security Administration** Division of Earnings and Business Services 6100 Wabash Ave. Baltimore, Maryland 21215

- **How much do I have to pay for an Itemized Statement of Earnings?**

Non-Certified Itemized Statement of Earnings	**Certified** Itemized Statement of Earnings
$115.00	$148.00

- **How much do I have to pay for Certified Yearly Totals of Earnings?**

Certified yearly totals of earnings cost $33.00. You may obtain non-certified yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	☐ Visa ☐ American Express ☐ MasterCard ☐ Discover
Credit Card Holder's Name (Enter the name from the credit card)	First Name, Middle Initial, Last Name
Credit Card Holder's Address	Number & Street City, State, & ZIP Code
Daytime Telephone Number	(☐☐☐) ☐☐☐ - ☐☐☐☐ Area Code
Credit Card Number	☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐
Credit Card Expiration Date	(MM/YY)
Amount Charged See above to select the correct fee for your request. Applicable fees are $33, $115, or $148 SSA will return forms without the appropriate fee.	$
Credit Card Holder's Signature	

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	

Form **8821**

(Rev. January 2018)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ **Go to *www.irs.gov/Form8821* for instructions and the latest information.**

▶ **Don't sign this form unless all applicable lines have been completed.**

▶ **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

For IRS Use Only

Received by:

Name

Telephone

Function

Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached ▶** ☐

Name and address	CAF No.
The Marker Group, Inc. 13105 NW Freeway, Suite 300 Houston, TX 77040	PTIN Telephone No. 713-934-2664 Fax No. 713-934-2665 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Income Tax	1040	2008-2017	

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you don't want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☒

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, partnership representative, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature Date

Print Name Title (if applicable)

Form **4506**

(July 2017)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

The Marker Group, Inc. - 13105 NW Freeway, Suite 300, Houston, TX 77040. Phone: 713-934-2664 / Fax: 713-934-2665

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☒

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

2008	2009	2010	

8 **Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.** **50.00**

a	Cost for each return	$
b	Number of returns requested on line 7	3
c	Total cost. Multiply line 8a by line 8b	$ 150.00

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☒

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☒ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** Date

Form **4506**

(July 2017)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

The Marker Group, Inc. - 13105 NW Freeway, Suite 300, Houston, TX 77040. Phone: 713-934-2664 / Fax: 713-934-2665

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☒

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

2011	2012	2013	2014
2015	2016	2017	

8 **Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.** **50.00**

a	Cost for each return	$
b	Number of returns requested on line 7	7
c	Total cost. Multiply line 8a by line 8b	$ 350.00

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☒

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☒ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions) | Date

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature | Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506, Form 4506-T and Form 4506T-EZ will be posted on that page.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of nonfiling, and records of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

CAUTION

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

_____
Full Name

_____
Social Security Number

_____
Date of Birth

AUTHORIZED IN CONNECTION WITH

In re: Roundup Products Liability Litigation
Northern District of California
No. 3:16-md-02741-VC

AUTHORIZATION FOR RELEASE OF DEPARTMENT OF REVENUE RECORDS

To: _____
Name of Entity

_____
Address

_____
City, State, Zip Code

I hereby authorize the law firm of HOLLINGSWORTH LLP, 1350 I Street, N.W., Washington, DC 20005, (202) 898-5800, or any member, associate, or designee of the firm to be furnished copies of the previously filed income tax returns filed by_____. Monsanto Company ("Monsanto"), a defendant in the above lawsuit, has agreed to pay reasonable charges to supply copies of such records.

This authorization is being given at my request in conjunction with the civil litigation matter listed above. Therefore, this authorization shall expire upon the final resolution by all parties of the aforementioned civil litigation, either by final adjudication, final settlement agreement, final judicial dismissal, or by other final judicial order, including but not limited to the resolution of any and all appeals. Until then, this authorization shall be considered as continuing, and you may rely on it in all respects unless and until you have been advised by me in writing to the contrary. Please note that this authorization also permits you to release any records created or obtained by you after the date of execution of this authorization.

It is expressly understood and intended by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to you.

Name	Signature	Date of Birth	Date Signed

Description of Legal Guardian/Personal Representative's Authority to Act