

HARBOUR HOUSE SOUTH CLASS ACTION SETTLEMENT

CLAIM FORM  
CRITICAL PERIOD BENEFITS: OPTION 2

To make a claim for Critical Period Benefits pursuant to Option 2, you must complete this entire Claim Form, sign it on the last page, and

NO LATER THAN MARCH 18, 2004  
mail it to:

Harbour House South Claims Office  
c/o Hamlin & Burton Liability Management  
111 W. Magnolia Avenue  
Suite 1000  
Longwood, Florida 32750  
1-866-332-4256

Attach additional sheets if space is insufficient. Please type or print legibly in ink.

If you submit this Claim Form for Option 2 Benefits and your claim is approved, you may receive the following:

1. A Per-Person Payment of \$3,000.00 (individually);
2. A Per-Unit Payment of 65% of your Harbour House South lease obligation during the Critical Period (subject to terms and conditions set forth in the Court Notice); AND
3. For Property Claims, reimbursement in an amount to be determined pursuant to the Claims Processing Protocol; AND/OR
4. For Medical Condition Claims arising during the Critical Period, reimbursement in an amount to be determined pursuant to the Claims Processing Protocol.

| PART A: IDENTIFICATION OF INDIVIDUAL CLAIMANT                                       |                            |                       |  |
|---|----------------------------|-----------------------|--|
| <i>First Name</i>   | <i>Middle Name/Initial</i> | <i>Last Name</i>      | <i>Social Security Number</i>            |
| <i>Other Names by Which You Also Are or Were Formerly Known (e.g., Maiden Name)</i> |                            |                       | <i>Date of Birth</i>                     |
| <i>Current Mailing Address (Street or P.O. Box)</i>                                 |                            | <i>E-mail Address</i> |  |
| <i>City</i>   | <i>State</i>               | <i>ZIP Code</i>       | <i>Telephone Number (with Area Code)</i> |

**PART B: RESIDENCY/CLASS MEMBERSHIP**

1. To show why you are entitled to Critical Period Benefits, check one box below:

- I am a **Lease Signatory** because I signed a lease with HHS entitling me to occupy, and I did occupy, a residential unit in Harbour House South between June 4, 2002 and January 9, 2003.
- I am a **Guest** because while I did not sign a lease with HHS, I did reside in a Harbour House South unit for a continuous period of at least 30 (thirty) days, at least a portion of which was between June 4, 2002 and January 9, 2003.

2. Identify the Harbour House South unit(s) you occupied and the period(s) during which you occupied them between June 4, 2002 and January 9, 2003:

Unit No. \_\_\_\_\_ from \_\_\_\_\_, 200\_\_ through \_\_\_\_\_, 200\_\_

Unit No. \_\_\_\_\_ from \_\_\_\_\_, 200\_\_ through \_\_\_\_\_, 200\_\_

3. As proof of my residency and membership in the Settlement Class, I am also attaching to this Claim Form one or more of the following **REQUIRED** documents:

- A copy or copies of the lease(s) I signed with HHS.
- A copy or copies of utility bills in my name for services, such as electricity, telephone, or cable television, provided to me at Harbour House South between June 4, 2002 and January 9, 2003.
- A notarized copy of a letter signed by at least one qualifying Lease Signatory attesting to the dates during which I resided in the Harbour House South unit leased to such Lease Signatory.
- I am not attaching any documents because I am a Lease Signatory listed on Exhibit A to the Agreement.

**PART C: YOUR CLAIMANT GROUP**

4. To identify other members of your Claimant Group(s), if any, check one box below and, if applicable, provide the names of the others in your Claimant Group(s).

- I am the **only member of my Claimant Group** because no other person occupied or resided in any Harbour House South unit(s) with me continuously for a period of at least 30 (thirty) days, at least a portion of which was between June 4, 2002 and January 9, 2003.
- Other Residents also belong to my Claimant Group(s).** Those persons listed below are either co-Lease Signatories or Guests who also belong to the Claimant Group(s) with respect to the unit(s) listed below.

Unit No. \_\_\_\_\_ : \_\_\_\_\_

Unit No. \_\_\_\_\_ : \_\_\_\_\_

**PART D: PER UNIT PAYMENT DATA**

5. To assist the Claims Office in calculating the proper Per-Unit Payment to be paid to you if you are the sole Lease Signatory, or jointly to you and your co-Lease Signatories, provide the data requested below.

For Unit No. \_\_\_\_\_ from \_\_\_\_\_, 200\_\_ through \_\_\_\_\_, 200\_\_, the monthly base lease obligation was \$ \_\_\_\_\_ / \_\_\_\_\_ Dollars.

While residing in this unit during this period, I withheld rent from HHS

never       between \_\_\_\_\_, 200\_\_ and \_\_\_\_\_, 200\_\_, because

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

For Unit No. \_\_\_\_\_ from \_\_\_\_\_, 200\_\_ through \_\_\_\_\_, 200\_\_, the monthly base lease obligation was \$ \_\_\_\_\_ / \_\_\_\_\_ Dollars.

While residing in this unit during this period, I withheld rent from HHS

never       between \_\_\_\_\_, 200\_\_ and \_\_\_\_\_, 200\_\_, because

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART E: PERSONAL PROPERTY CLAIMS**

6. If any of your personal property and effects located in Harbour House South were lost, stolen, or damaged, or you incurred increased utility expenses, as a result of the HVAC Shutdown and/or HHS's maintenance of Harbour House South, and you have not received compensation from or otherwise resolved your property damage claim with HHS,

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH ITEM OF DAMAGED PERSONAL PROPERTY FOR WHICH YOU SEEK BENEFITS.

For each item for which a claim is made, you must supply documentary proof of your damages and/or agree to an inspection of the item by the Claims Office.

Documentary proof may include videotape or photographs of the property; receipts or bills for cleaning, repair, restoration, or increased utility usage; appraisals; a BMS Non-Salvageable Inventory listing; and/or police reports.

ON EACH PIECE OF DOCUMENTARY PROOF ATTACHED TO OR PRESENTED WITH THIS CLAIM FORM, PLEASE IDENTIFY BY ITEM NO. THE ITEM OF PERSONAL PROPERTY TO WHICH THE PROOF PERTAINS.

If you need more space, attach additional sheets continuing the itemized list.

| Item No. | Description of Item                   | Docs. Attached  | Agree to Inspection   | Amount Claimed |
|----------|---------------------------------------|---|---|----------------|
| 6-1      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-2      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-3      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-4      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-5      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-6      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-7      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-8      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-9      |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-10     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-11     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-12     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-13     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-14     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-15     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-16     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-17     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-18     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-19     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
| 6-20     |                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | \$ _____.      |
|          | <b>Total Personal Property Claims</b> |   |   | \$ _____.      |

**PART F: MEDICAL CONDITION CLAIMS - RESOLUTION PROCESS**

7. To receive compensation for Medical Condition Claims arising as a result of exposure to mold at Harbour House South between June 4, 2002 and January 9, 2003, you may elect,

BY CHECKING EITHER BOX A OR BOX B BELOW,

EITHER

Box A  to receive a payment equal to 2.5 (two and one-half) times the total of all medical expenses you incurred from June 4, 2002 through August 26, 2003 for Covered Medical Conditions, which are the health conditions that, according to the American College of Occupational and Environmental Medicine ("ACOEM"), can occur from inhalation of and/or skin contact with common indoor molds. Those conditions are described in "Adverse Health Effects Associated with Mold in the Indoor Environment," issued by the ACOEM on October 27, 2002, and attached to the Settlement Agreement and available from the Claims Office.

OR

Box B  to resolve all your Medical Condition Claims through mediation by an independent, third-party mediator compensated from the Administrative Account (*provided* that in the event your Medical Condition Claims are not resolved through mediation, you may preserve your right to pursue compensation for such claims through jury trial by a Florida Court, pursuant to the terms and conditions of the Claims Processing Protocol).

WHETHER YOU CHOSE BOX A OR BOX B, GO TO QUESTION 8 TO ITEMIZE YOUR CLAIMS.

**PART G: MEDICAL CONDITION CLAIMS - ITEMIZATION**

8. FOR EACH MEDICAL CONDITION CLAIM FOR WHICH YOU SEEK BENEFITS, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW.

If you chose Box A, for each Covered Medical Condition for which a claim is made, supply documentary proof of the medical expenses you incurred.

Documentary proof may include medical records of health care professional(s) that relate to your treatment for a Covered Medical Condition; receipts for health care treatments showing a diagnosis of a Covered Medical Condition; and/or receipts for medications generally accepted and used for the treatment of Covered Medical Conditions.

ON EACH PIECE OF DOCUMENTARY PROOF ATTACHED TO OR PRESENTED WITH THIS CLAIM FORM, PLEASE IDENTIFY BY ITEM NO. THE COVERED MEDICAL CONDITION TO WHICH THE PROOF PERTAINS.

(If you chose Box B, you should still provide as much information as you can - with supporting documentation - to help facilitate a meaningful mediation.)

ALSO, for each Medical Condition Claim for which you seek benefits, please provide a statement explaining why you believe that the condition arose as a result of your exposure to mold at Harbour House South between June 4, 2002 and January 9, 2003.

If you need more space, attach additional sheets continuing the itemized list.

| Item No. | Medical Condition              | Docs. Attached  |  | Amount Claimed |
|----------|--------------------------------|---|--|----------------|
| 8-1      | <i>Name of Condition</i>       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  | \$ _____.      |
|          | <i>Explanation</i>             |   |  |                |
| 8-2      | <i>Name of Condition</i>       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  | \$ _____.      |
|          | <i>Explanation</i>             |   |  |                |
| 8-3      | <i>Name of Condition</i>       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  | \$ _____.      |
|          | <i>Explanation</i>             |   |  |                |
| 8-4      | <i>Name of Condition</i>       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  | \$ _____.      |
|          | <i>Explanation</i>             |   |  |                |
|          | Total Medical Condition Claims |   |  | \$ _____.      |

**PART H: SIGNATURE**

**ALL CLASS MEMBERS CLAIMING BENEFITS MUST COMPLETE AND SIGN BELOW**

I declare under penalty of perjury that the information on this Claim Form is true, correct, and complete to the best of my knowledge, information, and belief.

\_\_\_\_\_   
*Date Signed*

\_\_\_\_\_   
*Signature (Class Member or Representative\*)*

\*If you are NOT the Class Member identified in Part A, above, but are a representative filing this Claim Form on behalf of that Class Member, you MUST attach written proof that you have the legal authority to act as the Class Member's representative for purposes of claiming benefits under the Settlement Agreement.

**NOTE: To preserve eligibility for Option 2 Benefits under the Settlement, this Claim Form must be completed, signed, and mailed to the Claims Administrator, postmarked no later than March 18, 2004.**