GeneDx DNA DIAGNOSTIC EXPERTS — OncoGeneDx Test Requisition Form (Sanford Genetics)

Patient Information

First name Last name

Gender ☐ Male ☐ Female Date of birth (mm/dd/yy) _____

Ancestry ☐ Caucasian ☐ Eastern European ☐ Northern European
☐ Western European ☐ Native American ☐ Middle Eastern
☐ African American ☐ Asian ☐ Pacific Islander
☐ Caribbean ☐ Central/South American
☐ Ashkenazi Jewish ☐ Hispanic ☐ Other: _____

Mailing address

City State Zip code

Home phone Work phone

Patient's primary language if not English

Sample Information

Medical record # Specimen ID Date sample obtained (mm/dd/yy)

Specimen Type

☐ Blood in EDTA (5-6 mL in lavender top tube)

☐ DNA (>20 ug): Tissue source _____ concentration ___ (ug/ml) total Volume ___(ul)

☐ Oral Rinse (At least 30 mL of Scope oral rinse in a 50 mL centrifuge tube)

☐ Other _____(Call lab)

Patient has had a bone marrow transplant/transfusion ☐ Yes ☐ No

Date of last transfusion __/__/__ (must be at least 2 weeks prior to blood draw for testing)

Treatment-Related **RUSH**: _____ *(If known, please provide date)*

Clinical Diagnosis: _____ **ICD-10 Codes:** _____

Age at Initial Presentation: _____

Ordering Account Information

ZV255 Sanford Laboratories Sioux Falls

Acct # Account Name

Reporting Preference*. ☑ Care Evolve ☐ Fax ☐ Email

**If unmarked, we will use the account's default preferences or fax to new clients.*

Physician NPI #

Genetic Counselor
900 E 54TH ST NORTH

Street address 1

Street address 2
SIOUX FALLS SD 57104

City State Zip code
605-328-5493 605-328-5434

Phone Fax (important)

Email Beeper

Send Additional Report Copies To:

Physician or GC/Acct # Fax#/Email/CE #

Physician or GC/Acct # Fax#/Email/CE #

Statement of Medical Necessity

This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the tests(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Medical Professional Signature (required) Date

Patient Consent (sign here or on the consent document)

I have read the Informed Consent document and I give permission to GeneDx to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at GeneDx to improve genetic testing and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. I also give GeneDx permission to inform me in the future about research opportunities, including treatments for the condition in my family.

☐ Check this box, if you wish to opt out of any research studies.

☐ Check this box, if you do not wish to be contacted.

☐ Check this box if you are New York state resident, and give permission for GeneDx to retain any remaining sample longer than 60 days after the completion of testing.

Patient/Guardian Signature Date

Payment Options

Insurance Bill

Referral/Prior Authorization # _____

Please attach copy of Referral/authorization

Insurance Carrier Policy Name GeneDx Benefit Investigation #

Insurance ID # Group # Name of Insured Date of Birth Insurance Address City State Zip

Relationship to Insured ☐ Child ☐ Spouse ☐ Self ☐ Other _____

Secondary Insurance Carrier Name Insurance ID# Group # Name of Insured Date of Birth

Relationship to Insured ☐ Child ☐ Spouse ☐ Self ☐ Other _____

Please include a copy of the front and back of the patient's insurance card (include secondary when applicable)

If you would like to expedite the eligibility requirements for consideration of Financial Assistance, please provide number of Household Members _____ and Annual Adjusted Gross Income _____.

I represent that I am covered by insurance and authorize GeneDx, Inc. to give my designated insurance carrier, health plan, or third party administrator (collectively "Plan") the information on this form and other information provided by my healthcare provider necessary for reimbursement. I authorize GeneDx to inform my Plan of my test result only if test results are required for preauthorization of or payment for reflex/additional testing. I authorize Plan benefits to be payable to GeneDx. I understand that GeneDx will contact me if my out of pocket responsibility will be greater than $100 per test (for any reason, including co-insurance and deductible, or non-covered services). I will cooperate fully with GeneDx by providing all necessary documents needed for insurance billing and appeals. I understand that I am responsible for sending GeneDx any and all of the money that I receive directly from my insurance company in payment for this test. Reasonable collection and/or attorney's fees, including filing and service fees, shall be assessed if the account is sent to collection but said fees shall not exceed those permitted by state law. I permit a copy of this authorization to be used in place of the original.

Patient Signature (required) _____ Date _____

Institutional Bill

GeneDx Account #

Hospital/Lab Name

Contact Name

Address

City State Zip Code

Phone Fax

Patient Bill

Amount _____

I understand that my credit card will be charged the full amount for the testing.

Please bill my credit card (all major cards accepted)

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Name as it appears on card

Account Number Expiration date CVC

Signature Date

For GeneDx Use Only

OncoGeneDx Hereditary Cancer Testing (Sanford Genetics)

GeneDx DNA DIAGNOSTIC EXPERTS

ZV255 Sanford Laboratories Sioux Falls

Account # Account Name

First Name | Last Name | Date of Birth (mm/dd/yy)

Patient Clinical Information DETAILED MEDICAL RECORDS MUST BE ATTACHED

☐ **No Personal History of Cancer/Tumor**

Clinical Diagnosis:_____ **ICD-10 Codes:** _____ Diagnosis Age(s):_____

Clinical History

☐ **Breast Cancer(s)** Age(s) at Dx:_____ ER ___ PR ___ HER2 ___ ☐ triple negative
☐ Bilateral ☐ Two Primaries ☐ Invasive Ductal ☐ Invasive Lobular
☐ DCIS ☐ LCIS ☐ Other:_____

☐ **Ovarian Cancer(s)** Age(s) at Dx:_____
☐ Serous ☐ Mucinous ☐ Endometrioid ☐ Clear Cell
☐ LMP/Borderline ☐ Other:_____

☐ **Endometrial Cancer(s)** Age(s) at Dx:_____
☐ Serous ☐ Mucinous ☐ Endometrioid ☐ Clear Cell
☐ Sarcoma ☐ Other:_____

☐ **Pancreatic Cancer(s)** Age(s) at Dx:_____
☐ Adenocarcinoma ☐ IPMN ☐ Neuroendocrine ☐ Other:_____

☐ **Prostate Cancer** Age at Dx:_____ Gleason Score:_____

☐ **Melanoma(s)** Age(s) at Dx:_____ ☐ Invasive ☐ In-Situ

☐ **Hematologic Disease** Age(s) at Dx:_____ Diagnosis:_____
Status: ☐ Active/Residual Disease ☐ Remission

☐ **Colorectal Cancer(s)** Age(s) at Dx:_____ Pathology:_____
Location: ☐ Right ☐ Left ☐ Transverse ☐ Rectum

☐ **Polyp(s)** Age of first polyp:_____ ☐ Adenomatous - total #:_____
☐ Other - Pathology:_____ Other - total #:_____

☐ **Gastric Cancer(s)/Tumor(s)** Age(s) at Dx:_____ Pathology:_____

☐ **Endocrine Cancer(s)/Disease** Age(s) at Dx:_____
☐ Thyroid ☐ Pathology/Diagnosis:_____
☐ Pheochromocytoma (PCC) ☐ Paraganglioma (PGL) Location:_____
☐ Bilateral

☐ **Renal Cancer(s)/Tumor(s)** Age(s) at Dx:_____ ☐ Bilateral
☐ Clear Cell ☐ Papillary Type (I or II) :_____
☐ Transitional Cell ☐ Other:_____

☐ **Brain Cancer(s)/Tumor(s)** Age(s) at Dx:_____ Pathology:_____

☐ **Other Cancer/Tumor** _____ Age at Dx:_____

Patient Genetic Testing History

☐ **No Personal History of Genetic Testing**

Gene(s) Tested:_____ ☐ Positive _____ ☐ VUS _____ ☐ Negative

Patient Tumor Testing History

☐ **No Known Tumor Testing**

Tumor Type Tested:_____

MSI: ☐ Not Done ☐ High ☐ Stable ☐ Low
IHC: ☐ Not Done ☐ Present
☐ Absent IHC of:_____
Other:_____

MLH1 Methylation: ☐ Not Done ☐ Methylated - Tumor Only
☐ Methylated - Tumor and Normal Tissue ☐ Unmethylated
*BRAF*V600E: ☐ Not Done ☐ Present ☐ Absent

Please include copies of all previous genetic test results, tumor test results and detailed medical records.

Family History of Cancer(s)/Tumor(s)

☐ **No Known Family History of Cancer(s)/Tumor(s)**

☐ Pedigree Attached ☐ Adopted

Please include clinical details, such as bilateral, pathology (including triple negative breast cancer), premenopausal breast cancer, and Gleason score for prostate cancer, if available.

Relationship	Maternal	Paternal	Cancer/Tumor Site	Age at Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Previous Familial Genetic Testing

☐ **No Known Family History of Genetic Testing**

☐ Relative Tested:_____ ☐ Gene(s) Tested:_____ ☐ Positive _____ ☐ VUS _____ ☐ Negative

Please include copies of family members previous test results.

Additional Patient or Family Clinical History

OncoGeneDx Hereditary Cancer Testing (Sanford Genetics)

ZV255 Sanford Laboratories Sioux Falls

Account # Account Name

First Name Last Name Date of Birth (mm/dd/yy)

OncoGeneDx - Hereditary Cancer Test Menu

Breast/Ovarian Cancer

- ☐ **B361 *BRCA1/BRCA2* Ashkenazi Founder Panel** (Three Targeted Pathogenic Variants) Reflex to test code: _____
- ☐ **B362 *BRCA1/BRCA2* Sequencing and Deletion Duplication Analysis** Reflex to test code: _____
- ☐ **J055 Breast Cancer High/Moderate Risk Panel (9 genes)**

Multiple Cancers

- ☐ **B275 Comprehensive Cancer Panel (32 genes)**
- ☐ **B363 Rest of Comprehensive Cancer Panel (if first test is negative)[1]**

Colorectal Cancer

- ☐ **B274 Colorectal Cancer Panel (19 genes)**
- ☐ **B522 Lynch/Colorectal High Risk Panel (7 genes)**
- ☐ **B985 Lynch Syndrome Panel (5 genes)**
- ☐ **J006 *MSH2* Exons 1-7 Inversion Analysis[1]**

Other Cancers

- ☐ **B344 Endometrial Cancer Panel (12 genes)**
- ☐ **B399 Familial Cutaneous Malignant Melanoma (2 genes)[1]**
- ☐ **B343 Pancreatic Cancer Panel (16 genes)**
- ☐ **J318 Pediatric Tumor Panel (27 genes)[1]**
- ☐ **B395 PGL/PCC Panel (12 genes)[1]**
- ☐ **B394 Renal Cancer Panel (18 genes)[1]**

[1]*Rest of Comprehensive Cancer Panel is not available after BRCA1/BRCA2 (test codes B361 and B362) or test codes B394, B395, B399, J006 or J318.*

Reflex to Custom B749 OncoGeneDx Custom Panel

- ☐ **Sanford Breast/Ovarian Panel (22 genes)** *ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM,* FANCC, MLH1, MSH2, MSH6, NBN, NF1, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, TP53, XRCC2*
- ☐ **Rest of Sanford Breast/Ovarian Panel (if Test Code J055 is negative) (13 genes)** *BARD1, BRIP1, EPCAM*, FANCC, MLH1, MSH2, MSH6, NBN, NF1, PMS2, RAD51C, RAD51D, XRCC2*
- ☐ **Rest of Colorectal Panel (if Test Code B522 is negative) (12 genes)** *ATM, AXIN2, BMPR1A, CDH1, CHEK2, POLD1, POLE, PTEN, SCG5/GREM1*, SMAD4, STK11, TP53*

Please select one or more genes to create a custom panel (no minimum). Up to 61 genes are available.

☐ *ALK*	☐ *BRCA1*	☐ *CHEK2*	☐ *MEN1*	☐ *NBN*	☐ *POLE*	☐ *RET**	☐ *SMAD4*	☐ *TSC1*
☐ *APC*	☐ *BRCA2*	☐ *DICER1*	☐ *MET*	☐ *NF1*	☐ *PRKAR1A*	☐ *SCG5/GREM1**	☐ *SMARCA4*	☐ *TSC2*
☐ *ATM*	☐ *BRIP1*	☐ *EPCAM**	☐ *MITF**	☐ *NF2*	☐ *PTCH1*	☐ *SDHA*	☐ *SMARCB1*	☐ *VHL*
☐ *AXIN2*	☐ *CDC73*	☐ *FANCC*	☐ *MLH1*	☐ *PALB2*	☐ *PTEN*	☐ *SDHAF2*	☐ *STK11*	☐ *WT1*
☐ *BAP1*	☐ *CDH1*	☐ *FH*	☐ *MSH2*	☐ *PHOX2B**	☐ *RAD51C*	☐ *SDHB*	☐ *SUFU*	☐ *XRCC2*
☐ *BARD1*	☐ *CDK4*	☐ *FLCN*	☐ *MSH6*	☐ *PMS2*	☐ *RAD51D*	☐ *SDHC*	☐ *TMEM127*	
☐ *BMPR1A*	☐ *CDKN2A*	☐ *MAX*	☐ *MUTYH*	☐ *POLD1*	☐ *RB1*	☐ *SDHD*	☐ *TP53*	

☐ If OncoGeneDx Custom Panel is negative, reflex to test code: _____

*Testing includes sequencing and deletion duplication for all genes except *EPCAM* (del/dup only), *MITF* (evaluation of c.952G>A only), *PHOX2B* (seq only), *RET* (seq only), *SCG5/GREM1* (del/dup only)

Other Hereditary Cancers Test Menu

- ☐ **714 Birt-Hogg-Dube syndrome** (*FLCN*) (Seq & Del/Dup)
- ☐ **372 Bloom syndrome** (*BLM*) (Seq)
- ☐ **715 Carney complex** (*PRKAR1A*) (Seq & Del/Dup)
- ☐ **205 Gorlin syndrome** (*PTCH1*) (Seq & Del/Dup)
- ☐ **713 Hereditary leiomyomatosis and renal cell cancer** (*FH*) (Seq & Del/Dup)
- ☐ **721 Hyperparathyroidism-jaw tumor syndrome** (*CDC73*) (Seq & Del/Dup)
- ☐ **717 Juvenile polyposis syndrome** (*BMPR1A, SMAD4*) (Seq & Del/Dup)
- ☐ **718 Li-Fraumeni syndrome** (*TP53*) (Seq & Del/Dup)
- ☐ **719 Multiple endocrine neoplasia, type 1** (*MEN1*) (Seq & Del/Dup)
- ☐ **1771 Multiple endocrine neoplasia, types 2A and 2B** (*RET*) (Seq)
- ☐ **195 *PTEN* hamartoma tumor syndrome** (*PTEN*) (Seq & Del/Dup)
- ☐ **2071 Peutz-Jeghers syndrome** (*STK11*) (Seq & Del/Dup)
- ☐ **332 Von Hippel-Lindau syndrome** (*VHL*) (Seq & Del/Dup)

Targeted Variant Testing

☐ **B370 Testing for a previously identified variant**

Gene: _____ Variant: _____

Proband Name: _____ Relationship to proband: _____

Proband GeneDx Accession #: _____

☐ Positive control included/will be sent - **Positive control is recommended if previous test was performed at another lab.**

☐ Positive control not available. Please initial to acknowledge acceptance of caveat language on a negative report_____

☐ Family Member Test Report included - A clear copy of the test report on the positive family member is recommended if previous test was performed at another lab.

Variant Testing Program (requires lab approval)

☐ **B753 Previously identified variant of uncertain significance**

VTP Family ID: F_____

Gene(s): _____

Variant(s): _____

Proband Name: _____

Relationship to proband: _____

Proband GeneDx Accession #: _____

Hereditary Cancer Testing Panel Components

Breast Cancer High/Moderate Risk Panel (9 genes)	*ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, STK11, TP53*
Colorectal Cancer Panel (19 genes)	*APC, ATM, AXIN2, BMPR1A, CDH1, CHEK2, EPCAM*, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SCG5/GREM1*, SMAD4, STK11, TP53*
Comprehensive Cancer Panel (32 genes)	*APC, ATM, AXIN2, BARD1, BMPR1A, BRCA1, BRCA2, BRIP1, CDH1, CDK4, CDKN2A, CHEK2, EPCAM*, FANCC, MLH1, MSH2, MSH6, MUTYH, NBN, PALB2, PMS2, POLD1, POLE, PTEN, RAD51C, RAD51D, SCG5/GREM1*, SMAD4, STK11, TP53, VHL, XRCC2*
Endometrial Cancer Panel (12 genes)	*BRCA1, BRCA2, CHEK2, EPCAM*, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, PTEN, TP53*
Familial Cutaneous Malignant Melanoma (2 genes)	*CDK4, CDKN2A*
Lynch Sydrome Panel (5 Genes)	*EPCAM*, MLH1, MSH2, MSH6, PMS2*
Lynch/Colorectal High Risk Panel (7 genes)	*APC, EPCAM*, MLH1, MSH2, MSH6, MUTYH, PMS2*
Pancreatic Cancer Panel (16 genes)	*APC, ATM, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM*, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53, VHL, XRCC2*
Pediatric Tumor Panel (27 genes)	*ALK, APC, CDC73, DICER1, EPCAM*, MEN1, MLH1, MSH2, MSH6, NF1, NF2, PHOX2B*, PMS2, PRKAR1A, PTCH1, PTEN, RB1, RET*, SMARCA4, SMARCB1, STK11, SUFU, TP53, TSC1, TSC2, VHL, WT1*
PGL/PCC Panel (12 genes)	*FH, MAX, MEN1, NF1, RET*, SDHA, SDHAF2, SDHB, SDHC, SDHD, TMEM127, VHL*
Renal Cancer Panel (18 genes)	*BAP1, EPCAM*, FH, FLCN, MET, MITF*, MLH1, MSH2, MSH6, PMS2, PTEN, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL*

*Testing includes sequencing and deletion duplication for all genes except *EPCAM* (del/dup only), *MITF* (evaluation of c.952G>A only), *PHOX2B* (seq only), *RET* (seq only), *SCG5/GREM1* (del/dup only)

SANFORD imagenetics

Informed Consent for Genetic Testing

Person being tested _____ E#MRN_____Date of Birth _____

Based on my health and/or family history, I am asking for genetic testing for _____ (person).

This testing is for _____.

Name of lab where this test is being done: _____.

Steps for testing

- I have had genetic counseling with _____ before the test.
- Related health and family history have been discussed with me.
- I have been told the risks and benefits of this test.
- The specimen type that will be sent for testing is _____.
- Results will be ready in about _____.
- Results will be given by way of _____.
- When results are ready I can choose to receive them, delay receiving them, or say no to receiving them.

Results of the testing

The test results will be sent to the provider involved in the genetic testing.
Genetic test results may include but are not limited to a:

- Positive result (shows a genetic finding) which gives clues about:
  - A diagnosis, and/or
  - The carrier status of a genetic condition, and/or
  - The possibility of getting a genetic disease in the future.
- Negative result (no genetic change found in this test)
  - This does not mean the disease in question will not occur or is not already present.
- Variant (a genetic change which may or may not have meaning now)

I know there is sometimes a need for another specimen to be collected to get clear results.
A follow-up appointment may be needed for further genetic counseling.

I understand:

- The results might help me make informed choices about future health care.
- Not all genetic tests have health care guidelines.
- A genetic test result does not mean that a health insurance company will cover the cost of needed health care.
- An appointment and/or testing for family members may be suggested.
- It is possible for genetic testing to reveal facts that are not related to the reason for the test.

Limits of testing

- This test is only looking for genetic changes in the areas covered by the test.
- There may be a genetic change outside the area tested. This change will not be found by the test.
- There may be an error in the test results. This can be caused by:
  - Contamination of the specimen.
  - Errors while testing the specimen.
  - Incorrect reporting of health or family history.

Privacy

I understand:

- My genetic test results will be a part of my health record.
- The confidentiality of my medical record is protected by the federal privacy law known as HIPAA (Health Insurance Portability and Accountability Act).

Person being tested _____ **E#MRN** _____ **Date of Birth** _____

- How information in my medical record is accessed, used, and disclosed is explained in Sanford Health's Notice of Privacy Practices.
- Federal law does not allow health insurers and employers to discriminate based on genetic information. This law is known as the Genetic Information Non-discrimination Act of 2008 (Public Law 110-233).
- I can consult with my legal advisor to find out what impact the genetic test results may have on my life, long term care, or disability insurance.

Specimen Storage

Some laboratories may keep the specimen after the genetic test is done.

- There may be some personal information attached to the specimen. This is so more testing may be done, if I ask for it.
- Personal information may be removed from the specimen to use it for research and making new tests.
- I have been given the choice to accept or decline having the specimen placed in storage for further testing.

Price of testing

I understand:

- The estimated price of the test is $_____ .
  - I may be called and told the price of the test by the laboratory. What I pay for this test will be based on my insurance policy if my insurance company is billed.
  - A preauthorization may be needed from my insurance company.
- This will be done by _____ .
  - The response from my insurance company may come to me, my doctor, or to my genetic counselor.
- This test may not be paid by insurance. I may have to pay for this test.
- I should be sent an explanation of benefits (EOB) from my insurance company. This EOB is not a bill.
- The bill for the test will be sent from _____ .
- For questions about the bill, call _____ .

I have read this form or it has been explained to me.
I have been given the chance to ask all my questions.
I have been told and understand the risks and other choices I have related to genetic testing.

I agree to have the genetic test indicated above.

_____

Patient | Person giving form | Date | Time

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____ , hereby certify that I am the _____ of the patient and that the patient is unable to consent because the patient is a minor or because _____ .

_____

Signature of Parent, or Legal Guardian, or Patient Advocate or Next of Kin | Date | Time

_____

Witness to Signature | Date | Time

GeneDx
DNA DIAGNOSTIC EXPERTS

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: