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DECEASED CLAIMANT FORM

City of Detroit Bankruptcy Claim
UNITED STATES BANKRUPTCY COURT
CASE NO. 13-53846

THIS FORM IS BEING COMPLETED, UNDER PENALTY OF PERJURY, CONCERNING A DECEASED CLAIMANT AND FUNDS WHICH SHE/HE MAY HAVE BEEN ENTITLED TO WHILE ALIVE, AS A RESULT OF HIS/HER EMPLOYMENT WITH THE CITY OF DETROIT AND THE RESOLUTION OF A SERIES OF PENDING CLAIMS AGAINST THE CITY BY THE UNITED STATES BANKRUPTCY COURT ("FUNDS"). PLEASE PROVIDE THE INFORMATION BELOW SO THAT YOUR CLAIM CAN BE PROCESSED AND IT CAN BE DETERMINED WHETHER THE DECEASED CLAIMANT'S HEIRS ARE ENTITLED TO THE FUNDS.

TO BE ELIGIBLE TO RECEIVE A SHARE OF THE PROCEEDS IN CONNECTION WITH THE CITY OF DETRIOT BANKRUPTCY CLAIM YOU MUST COMPLETE AND SIGN THIS PROOF OF CLAIM FORM ("CLAIM FORM") AND TAX FORM (W-9) AND MAIL IT BY PREPAID, FIRST-CLASS MAIL, **POSTMARKED NO LATER THAN NOVEMBER 20, 2025**, TO THE FOLLOWING ADDRESS:

City of Detroit Bankruptcy Claim
c/o Epiq
PO Box 5439
Portland, OR 97228-5439

ALTERNATIVELY, YOU MAY OBTAIN, COMPLETE, AND SUBMIT AN ELECTRONIC CLAIM AND TAX FORM **BY 11:59 P.M. EST ON NOVEMBER 20, 2025** AT **WWW.CITYOFDETROITBANKRUPTCYCLAIM.COM**.

CLAIM AND TAX FORMS THAT ARE NOT MAILED BY PREPAID FIRST-CLASS MAIL AND/OR ARE RECEIVED WITH NO POSTMARK WILL BE DEEMED TO HAVE BEEN SUBMITTED ON THE DATE OF RECEIPT.

FAILURE TO TIMELY SUBMIT THE NECESSARY FORMS WILL RESULT IN YOU NOT SHARING IN THE PROCEEDS.

DO NOT MAIL OR DELIVER YOUR CLAIM FORM OR TAX FORM TO THE COURT, THE CITY OF DETROIT, AFSCME, OR THE ATTORNEYS OF RECORD.

GENERAL INSTRUCTIONS

1. **CLAIM FORM:** In order to share in the proceeds from the AFSCME bankruptcy claim you must submit the attached Claim Form. You must fill out all applicable information on the Claim Form and Sign and Date the Claim Form.

2. **TAX FORM:** In order to share in the proceeds from the AFSCME bankruptcy claim, you must submit the attached W-9 tax form. You must fill out all applicable information on the Tax Form and Sign and Date the Tax Form. All eligible beneficiaries must provide a fully completed and signed tax form in order to share in the proceeds.

3. **DO NOT SEND ORIGINAL DOCUMENTS.** Please keep a copy of all documents that you send to the Claims Administrator. Also, please do not highlight any portion of the Claim Form or any supporting documents.

4. By submitting this Claim Form, you will be making a request to share in the proceeds of the AFSCME Bankruptcy Fund. If the claimant was NOT an employee of the City of Detroit and represented by AFSCME at any time from 2009 to 2013, DO NOT submit a Claim Form. **You may not share in the proceeds of the AFSCME Bankruptcy Fund if the claimant was not an employee of the City of Detroit and represented by AFSCME from 2009 to 2013.** Thus, if the Claimant was not eligible, any Claim Form that you submit, or that may be submitted on your behalf, will not be accepted.

5. If you have questions concerning the Claim Form or need additional copies of the Claim Form or related documents, you may contact the Claims Administrator, Epiq, by writing to the above address, by calling the toll-free hotline at 1-888-868-4941 or by sending an email to info@CityofDetriotBankruptcyClaim.com, or you may download the documents from www.CityofDetriotBankruptcyClaim.com.

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IMPORTANT: PLEASE NOTE

YOUR CLAIM IS NOT DEEMED FILED UNTIL YOU RECEIVE AN ACKNOWLEDGEMENT BY MAIL OR EMAIL. THE CLAIMS ADMINISTRATOR WILL ACKNOWLEDGE RECEIPT OF YOUR CLAIM FORM BY MAIL OR EMAIL, WITHIN 60 DAYS. IF YOU DO NOT RECEIVE AN ACKNOWLEDGEMENT WITHIN 60 DAYS, PLEASE CALL THE CLAIMS ADMINISTRATOR TOLL-FREE AT (888) 868-4941.

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PART I – DECEASED CLAIMANT INFORMATION

PLEASE COMPLETE THIS PART I IN ITS ENTIRETY AS TO THE LAST KNOWN INFORMATION RELATED TO THE DECEASED FORMER EMPLOYEE OF THE CITY OF DETROIT. THE CLAIMS ADMINISTRATOR WILL USE THIS INFORMATION TO VERIFY ELIGIBILITY.

First Name | MI | Last Name

Prior Name(s) (if name has changed since 2009)

Address 1 (street name and number)

Address 2 (apartment, unit or box number)

City | State | ZIP Code

Country

Last four digits of Social Security Number or Taxpayer Identification Number

Primary Phone Number – –

Alternate Phone Number – –

Email Address

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PART II – CLAMANT ELIGIBILITY

Was the Deceased Claimant a City of Detroit employee who was represented by AFSCME at any time during the time period of 2009 to 2013?	Check One ☐ Yes ☐ No

IF THE ANSWER ABOVE IS "YES" PLEASE PROVIDE ANY DOCUMENTATION DEMONSTRATING SUCH.

PART III – BENEFICIARY INFORMATION

PLEASE LIST THE NAME AND ADDRESS OF THE FOLLOWING INDIVIDUALS FOR PURPOSES OF BENEFICIARY INFORMATION.

A. SURVIVING SPOUSE

PLEASE COMPLETE THIS PART A IN ITS ENTIRETY. THE CLAIMS ADMINISTRATOR WILL USE THIS INFORMATION FOR ALL COMMUNICATIONS REGARDING THIS CLAIM FORM. IF THIS INFORMATION CHANGES, YOU MUST NOTIFY THE CLAIMS ADMINISTRATOR IN WRITING AT THE ADDRESS ABOVE.

First Name | MI | Last Name

Address 1 (street name and number)

Address 2 (apartment, unit or box number)

City | State | ZIP Code

Country

Last four digits of Social Security Number or Taxpayer Identification Number

Primary Phone Number – –

Alternate Phone Number – –

Email Address

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B. SURVIVING CHILDREN

IF THERE IS NO SPOUSE, LIST ALL SURVIVING CHILDREN.

PLEASE COMPLETE THIS PART B IN ITS ENTIRETY. THE CLAIMS ADMINISTRATOR WILL USE THIS INFORMATION FOR ALL COMMUNICATIONS REGARDING THIS CLAIM FORM. IF THIS INFORMATION CHANGES, YOU MUST NOTIFY THE CLAIMS ADMINISTRATOR IN WRITING AT THE ADDRESS ABOVE.

First Name | MI | Last Name

Address 1 (street name and number)

Address 2 (apartment, unit or box number)

City | State | ZIP Code

Country

Last four digits of Social Security Number or Taxpayer Identification Number

Primary Phone Number – –

Alternate Phone Number – –

Email Address

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C. OTHER POSSIBLE BENEFICIARIES

IF NO SURVIVING SPOUSE OR SURVIVING CHILDREN, PROVIDE THE INFORMATION FOR SURVIVING PARENTS, SISTERS OR BROTHERS.

PLEASE COMPLETE THIS PART C IN ITS ENTIRETY. THE CLAIMS ADMINISTRATOR WILL USE THIS INFORMATION FOR ALL COMMUNICATIONS REGARDING THIS CLAIM FORM. IF THIS INFORMATION CHANGES, YOU MUST NOTIFY THE CLAIMS ADMINISTRATOR IN WRITING AT THE ADDRESS ABOVE.

First Name | MI | Last Name

Relationship to Deceased Claimant

Address 1 (street name and number)

Address 2 (apartment, unit or box number)

City | State | ZIP Code

Country

Last four digits of Social Security Number or Taxpayer Identification Number

Primary Phone Number – –

Alternate Phone Number – –

Email Address

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PART IV – ESTATE

Indicate whether the Deceased Claimant has estate opened on his/her behalf in probate court.	Check One ☐ Yes ☐ No

If yes, provide the Case Number and all orders of the court concerning the matter that entitle the Deceased Claimant's Funds to be distributed (such as orders of the probate court and letter(s) of administration allowing a personal representative to receive all funds due to the Deceased Claimant).

Indicate whether the Deceased Claimant made any statement or other instrument that calls for how his/her Funds must be distributed.	Check One ☐ Yes ☐ No

If yes, provide a copy of that statement.

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PART V – SIGNATURE

CERTIFICATION

By signing and submitting this Claim Form, the Claimant(s) or the person(s) who represent(s) the Claimant(s) certifies (certify), as follows:

1. that I (we) have read and understand the contents of this Claim Form.
2. that the Claimant(s) is a (are) eligible to share in the proceeds of the AFSCME Bankruptcy Fund as defined in this Claim Form.
3. that the Claimant(s) has (have) not submitted any other Claim covering the same individual and knows (know) of no other person having done so on the Claimant's (Claimants') behalf.
4. that I (we) agree to furnish such additional information with respect to this Claim Form, the Claims Administrator or the Court may require.

UNDER THE PENALTIES OF PERJURY, I (WE) CERTIFY THAT ALL OF THE INFORMATION PROVIDED BY ME (US) ON THIS CLAIM FORM IS TRUE, CORRECT, AND COMPLETE, AND THAT THE DOCUMENTS SUBMITTED HEREWITH ARE TRUE AND CORRECT COPIES OF WHAT THEY PURPORT TO BE.

(Sign your name here)

Date: MM – DD – YYYY