GURBIR S. GREWAL
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Richard J. Hughes Justice Complex
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Attorney for Plaintiff

By: Brian R. Fitzgerald
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SUPERIOR COURT OF NEW JERSEY
SPECIAL CIVIL PART - MONMOUTH COUNTY
DOCKET NO. MON-DC-006241-19

MARLENE CARIDE, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiff, v. HARMONY B. HEFFERNAN, Defendant.	**Civil Action** **NOTICE OF MOTION FOR SUMMARY JUDGMENT** **SPECIAL CIVIL PART:** **STATUTORY PENALTIES AMOUNT IN CONTROVERSY:** **$8,860.00**

To:
Hon. Daniel L. Weiss
Monmouth County Courthouse
Special Civil Part
71 Monument Park
P.O Box 1270
Freehold, NJ 07728

Harmony B. Heffernan
76 Alexander Drive
Red Bank, NJ 07701

PLEASE TAKE NOTICE that the undersigned attorney for Plaintiff, Marlene Caride, the Commissioner for the New Jersey

Department of Banking and Insurance ("Plaintiff"), will apply to the Superior Court of New Jersey, Special Civil Part, Monmouth County, for an Order for a Summary Judgment against the Defendant, Harmony B. Heffernan ("Defendant"), in the above-captioned matter in favor of the Plaintiff, in the amount of $8,860.00. This amount consists of civil penalties of $5,000.00, pursuant to N.J.S.A. 17:33A-5(b); attorneys' fees of $2,860.00, pursuant to N.J.S.A. 17:33A-5(b); and $1,000.00 constituting an insurance fraud surcharge, pursuant to N.J.S.A. 17:33A-5.1.

Plaintiff will rely upon the Certification of Brian R. Fitzgerald, the Certification of Thomas D. Uram, and the letter brief submitted with this Notice of Motion.

No oral argument is requested unless an opposition is received.

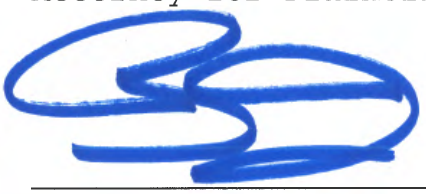
In accordance with R. 1:6-2, this matter is scheduled for trial on October 21, 2019. There is no discovery end date set.

"NOTICE. IF YOU WANT TO RESPOND TO THIS MOTION YOU MUST DO SO IN WRITING. Your written response must be in the form of a certification or affidavit. That means that the person signing it swears to the truth of the statements in the certification or affidavit and is aware that the court can punish him or her if the statements are knowingly false. You may ask for oral argument, which means you can ask to appear before the court to explain your position. If the court grants oral argument, you will be notified

of the time, date, and place. Your response, if any, must be in writing even if you request oral argument. Any papers you send to the court must also be sent to the opposing party's attorney or the opposing party if they are not represented by an attorney."

"We are asking the court to make a final decision against you without a trial or an opportunity for you to present your case to a judge. We are requesting that a decision be entered against you because we say that the important facts are not in dispute and the law entitles us to a judgment. If you object to this motion, you must file a written response stating that facts are disputed and why a decision should not be entered against you."

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY
Attorney for Plaintiff

By: 

Brian R. Fitzgerald
Deputy Attorney General

Dated: August 21, 2019

GURBIR S. GREWAL
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Richard J. Hughes Justice Complex
25 Market Street
P.O. Box 117
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Attorney for Plaintiff

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SUPERIOR COURT OF NEW JERSEY
SPECIAL CIVIL PART - MONMOUTH COUNTY
DOCKET NO. MON-DC-006241-19

MARLENE CARIDE, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiff, v. HARMONY B. HEFFERNAN, Defendant.	**Civil Action** **CERTIFICATION OF THOMAS D. URAM**

I, Thomas D. Uram, of full age, do of my own personal knowledge hereby certify, in lieu of an affidavit pursuant to R. 1:4-4(b):

1. I am an Investigator with the Bureau of Fraud Deterrence. I am the Investigator assigned to this case and am fully familiar with the facts set forth herein.

2. On March 28, 2017, Defendant Harmony B. Heffernan ("Defendant") applied to Mutual of Omaha Insurance Company ("Mutual of Omaha") for an individual disability insurance policy. (Attached as Exhibit A is a true and exact copy of Defendant's application to Mutual of Omaha.)

3. On April 5, 2017, Defendant was injured at his place of employment. (Attached ax Exhibit B is a true and exact copy of an Attending Physician's Statement concerning Defendant's injury.)

4. On April 6, 2017, Defendant ceased working due to disability. (See Ex. B.)

5. On April 11, in order to obtain the individual disability insurance policy, and as a prerequisite for the policy to be effective, Defendant signed a "Policy Delivery Receipt and Statement of Good Health" ("Statement of Good Health"), representing, among other things, that between the application date, March 28, 2017, and the effective date of the policy, that: there had been no change in Defendant's occupational status; there had been no change in Defendant's health; and Defendant had not suffered any illness or injury. (Attached as Exhibit C is a true and exact copy of the Statement of Good Health.)

6. On April 12, 2017, the policy was issued with an effective date of April 11, 2017. (Attached as Exhibit D is a true and exact copy of the Record Adjustment for Defendant's

policy.)

7. On or about November 22, 2017, Defendant filed a claim for disability benefits. In the documentation Defendant submitted to Mutual of Omaha in support of his claim, Defendant disclosed that he was injured on April 5, 2017. (Attached as Exhibit E are true and correct copies of claim document submitted to Mutual of Omaha by Defendant.)

8. Had Defendant disclosed his injury and change in occupational status on the Statement of Good Health, Mutual of Omaha would not have issued the policy. (Attached as Exhibit F is a true and exact copy of an e-mail (redacted) from Melissa Holm, Senior Corporate Investigator, Mutual of Omaha.)

9. Mutual of Omaha rescinded the policy on April 6, 2018 due to Defendant's misrepresentations. (Attached as Exhibit G is a true and exact copy of a letter to Defendant from Jan Hoden, LTD Claims Analyst, Mutual of Omaha, dated April 6, 2018.)

10. Confidential personal identifiers have been redacted from documents now submitted to the court in accordance with R. 1:38-7(b).

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Thomas D. Uram

Thomas D. Uram

Dated: 8/21/19

EXHIBIT A

Manager/Commission Code (Required Field for Brokerage)	

MUTUAL OF OMAHA INSURANCE COMPANY

Application for Individual Disability Income Insurance

Mutual of Omaha

SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

COVERAGE(S) APPLYING FOR

Program	Product
☑ Individual DI	☐ Accident-Only Disability Income

PROPOSED INSURED INFORMATION

Proposed Insured's Name (First, Middle, Last)	Gender	Date of Birth	Birth State
HARMONY BARRY HEFFERNAN	☑ Male ☐ Female	[redacted]	NJ

Primary Residence Address (Number, Street, City, State, Zip)	Social Security Number
6 ALEXANDER DRIVE RED BANK NJ 0770	[redacted]

Mailing Address for Premium Notices (if different than above)	Telephone Number	Best Time to Call
	(732) 502-4793	A.M. P.M.

Full Name of Beneficiary: SUSAN HEFFERNAN — Relationship to Proposed Insured:

☑ U.S. Citizen
☐ Permanent Resident (Form I-551) Cardholder residing in the U.S. at least 3 consecutive years (Complete Foreign Travel Questionnaire)

During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? ☐ Yes ☑ No

EMPLOYMENT INFORMATION

☑ Employee (No Ownership) ☐ Sole Proprietor ☐ Partnership ☐ "S" Corp ☐ "C" Corp % Ownership ____ # of Employees ____

Employer: APM TERMINALS (City, State) NY NY

Occupation: MECHANIC / SERVICE List exact duties: SERVICE & MECHANIC

1. Are you considered a full-time employee by your employer? ☑ Yes ☐ No # of hours/week 40+
2. How long have you been employed by your current employer? 5yrs
3. Do you have any part-time or off-season occupation? ☐ Yes ☑ No (If "Yes," list exact duties/hours per week)

OTHER COVERAGE AND REPLACEMENT INFORMATION

1. Are you covered under or eligible for: (Check all that apply) ☐ (FERS or CSRS) ☐ Railroad Retirement Act ☑ Workers Compensation
2. Are you covered under any State Disability Program? ☐ Yes ☑ No
3. Are you currently applying for, or do you have in force other disability income coverage, such as: (a) Individual Disability Income; (b) Sick Pay, Association, Retirement/Pension Group Disability Plan; or (c) Business Expense or Buy/Sell Insurance? ☐ Yes ☑ No
   If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (a,b,c)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
							☐ Yes ☑ No
							☐ Yes ☑ No

4. **Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.** I am requesting termination of my Policy No. _____ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

INCOME INFORMATION

1. Income information (Attach financial records if required. See underwriting guide for details)	Year-to-Date	Prior Year	2nd Prior Year
(a) Gross Annual Earned Income	$ 20,000+	22,000+	20,000+
(b) If self employed, net annual earned income from your occupation (after business expenses and before taxes)	$		
(c) Bonus, First Year Commissions and other incentive payments	$		
(d) Other Earned Income (Part-time, off-season, etc.)	$		
Total	$		

2. During the preceding tax year, did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month?
   ☐ Yes ☑ No If "Yes," how much per month? _____

SECTION B — GENERAL UNDERWRITING INFORMATION

1. Have you been able to perform all the material and substantial duties of your job for the last 6 months? ☑ Yes ☐ No
2. Height (Ft & In) 5'11" Weight (Lbs) 235
3. In the past 6 months, due to either an accident, sickness or chronic condition other than colds, flu or childbirth, have you . . .
   (a) missed 5 consecutive days or more of work? ☐ Yes ☑ No
   (b) been admitted to the hospital? ☐ Yes ☑ No
4. In the past 2 years, have you applied for or received disability benefits? ☐ Yes ☑ No
   If "Yes", provide details/date _____
5. Have you participated in hang gliding, rock or mountain climbing, sky, skin or scuba diving, motor vehicle, motor cycle or watercraft racing, bike or ski racing (including exhibition), rodeoing or organized boxing or fighting within the last 3 years or plan such activity in the next 2 years? ☐ Yes ☑ No
   (If "Yes," submit an Avocation Questionnaire)
6. In the past 3 years, have you been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, been convicted or plead guilty four or more times for moving violations or had a driver's license suspended or revoked? ☐ Yes ☑ No
   If "Yes", provide details _____
7. Have you filed for bankruptcy in the last 2 years? ☐ Yes ☑ No
8. In the past 3 years, have you been diagnosed, received treatment, tested positive for or been given medical advice by a member of the medical profession for any of the following conditions? Check all that apply.

- ☐ Alcoholism or Drug Abuse
- ☐ Alzheimer's or Dementia
- ☐ Bipolar, Manic Depression or Schizophrenia
- ☐ Cardiomyapathy
- ☐ Chronic back, neck or joint condition with ongoing treatment or treatment lasting more than 12 months
- ☐ Chronic or Recurring Neuritis (Including Optic & Vestibular Neuritis)
- ☐ Epilepsy with seizure in the last 12 months
- ☐ Hemophilia
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Narcolepsy
- ☐ Parkinson's
- ☐ Pulmonary Embolism or Pulmonary Infarction
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma or Polymyositis
- ☐ Systemic Lupus Erythematosus (SLE)
- ☑ **None of These**

Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability? ☐ Yes ☑ No

If you answered "Yes", provide additional details below. Attach a separate signed sheet if necessary.

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Details of Treatment	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

SECTION C — PLAN INFORMATION

ACCIDENT ONLY DISABILITY INSURANCE

Monthly Benefit Amount $ 5,000

Elimination Period: ☐ 0 Days ☐ 7 Days ☑ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 6 Months ☐ 12 Months ☑ 24 Months

Optional Riders:

- ☑ Hospital Confinement Accident Indemnity Benefits Rider ☐ $125 ☑ $250
- ☑ Accident Medical Expense Rider ☐ $1,000 ☐ $2,000 ☐ $3,000 ☑ $5,000

MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 800-775-6000

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: Harmony Helexander Policy Number(s) if known: /

Complete this form only when authorizing a bank account withdrawal for premium payment.

PAYMENT INFORMATION

1. **Initial Premium Payment**

☑ Automated Bank Account Withdrawal ☐ Check Amount Quoted $ 33.07

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AT POLICY ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**

☑ Automated Bank Account Withdrawal (Monthly)

Specify the date premiums will be withdrawn: ☐ 1st of the Month or ☑ 15th of the Month

Ongoing premiums are due and will be automatically withdrawn from the account below on the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

☐ Direct Bill (select one) ☐ Annual ☐ Semiannual ☐ Quarterly

PAYOR INFORMATION

Name of payor as shown on bank account: _____ Social Security No. _____

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

☐ Employer ☐ Living Trust
☐ Business owned by Proposed Insured/Insured or Spouse ☐ Other _____
☐ Power of Attorney or legal guardian

ACCOUNT INFORMATION

1. Account Type (check one): ☑ Checking ☐ Savings
2. Name of Financial Institution: PNC BANK
3. Complete information below or attach a voided check here.
   Bank Routing Number: [redacted] Bank Account Number: [redacted] (Do not use Debit/Credit Card numbers)

Memo _____ Signed By: _____

⑆123456789⑆ 12345678⑈ 1234⑈

Bank Routing Number | Bank Account Number | Check Number (if shown at bottom, may be shown before or after the account #)

AUTHORIZATION

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date 5/28/19 Mo./Day/Yr. [signature] Authorized Signature as Shown on Account

M28560

8625/0-92

SECTION D BILLING

Initial
- ☐ Check submitted with application
  Amount collected $ _____
- ☑ Automated Bank Account Withdrawal
- ☐ Collect on delivery

Renewal
Amount $ 133.07
- ☐ Monthly (Automated Bank Account Withdrawal)
- ☐ Quarterly
- ☐ Semi-Annual
- ☐ Annual

Note: If Automated Bank Account Withdrawal is selected, please complete the Payment Authorization Form.

Requested Effective Date: _____ Payroll Deduction (PRD) Group Number: _____

SECTION E PLEASE READ AND SIGN

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company ("Mutual of Omaha") will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha may require: medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha, (b) Mutual of Omaha receives any additional information requested for underwriting, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha then in force.
4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions under any temporary insurance agreement or conditional receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. A completed and signed application will become part of each applicant's policy.
6. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

FRAUD WARNING – Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I have (a) read and understand the Agreements and Acknowledgements and Fraud Warning Sections; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: Red Bank NJ
City State Date

Signature of Proposed Insured — H. Barry Heffernan — Printed Name of Proposed Insured — 3/28/17 Date

Signature of Payor as shown on bank account (If Billing Mode is BSP and Payor is other than Proposed Insured) — Printed Name of Payor — Date

Producer Section:

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☑ Yes ☐ No

(If "No," please explain.)

I conducted said interview in person ☐ Yes ☑ No

(If "No," please explain.) Client too Busy to meet

Signature of Producer — Producer's Printed Name — Date 3/28/17

Office Name — Office Address 109 Interchange Plaza

Signature of Producer — Producer's Printed Name — Date

Office Name — Office Address Suite 102 Monroe Township NJ 08831

MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that if the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

Name(s) used for medical records (if different than the name) below: Harmony Barry Heflexner

Signature of Proposed Insured — **Date:** 3 / 28 / 17 (Mo / Day / Yr)

Signature of Spouse/Civil Union Partner (if Proposed Insured) — **Date:** ____ / ____ / ____ (Mo / Day / Yr)

Signature of Parent or Guardian (if Proposed Insured is a Minor) — **Date:** ____ / ____ / ____ (Mo / Day / Yr)

Signature of Non-minor Child (if Proposed Insured is a Non-minor) — **Date:** ____ / ____ / ____ (Mo / Day / Yr)

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

L8232_CUP_0913

AGENT/PRODUCER STATEMENT

Proposed Insured: Harmony Barry H Brown

CONTACT INFORMATION

Division Office/MGA KJ Division Phone Number 609 655-3066

Contact (if different than above, who should we contact on this case)

Name Paula Gerard Phone Number (908) 208-8234

E-mail Address paula.gerard@mutualofomaha.com

COMMISSION INFORMATION

Producer Name Paula Gerard Production Number 1676G5

Last 4 digits of Social Security Number 8200 Commission % Share 100%

If second producer, please complete below:

Producer Name _____ Production Number _____

Last 4 digits of Social Security Number _____ Commission % Share _____

INDIVIDUAL DISABILITY

Occupational Class Quoted: (check one)

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☑ 1A

Applying for Discount (check one). Attach illustration.

☐ Association Group (Marketing verification form M27646 required)

Association Name _____

Association Number _____

Date Joined (Mo./Yr.) _____

☐ Self-Employed (submit financials)

☐ Common Employer (Not approved in FL, GA, KS, MD, OH, RI, SC, SD, UT, VT, VI)

Group Number _____

Employer's Name _____ Address _____

List all associated Common Employer Applicants _____

☐ Life/DI (Not approved in FL, GA, KS, MD, OH, RI, SC, SD, UT, VT, VI)

Life Policy Number _____

Student Program

☐ Program of Study _____

DI CHOICE AT WORK

(check if applies) Group Name _____ Group Number _____

☐ GSI (Mandatory) ☐ ESI

☐ GSI (Voluntary) ☐ Fully Underwritten

What type of application are you submitting? (Complete if applying for GSI or ESI only)

☐ Original Enrollment ☐ New Hire ☐ Annual Enrollment (ESI)

Occupation Class Quoted: (check one)

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ 1A

If business owner, has Business Owner Upgrade been applied? ☐ Yes ☐ No

56412

UNDERWRITING REQUIREMENTS

Please check the underwriting requirements that have been ordered if applicable:

Type of Requirement:

- [x] Client Interview (call 1-800-775-3000)
- [ ] Blood/Urine Profile/Physical Data

Ordered Through:

- [ ] American Para Professional Systems (APPS) 1-800-635-1677
- [ ] Hooper Holmes 1-800-765-1010
- [ ] Exam One 1-877-933-9261
- [ ] Examination Management Services, Inc. (EMSI) 1-800-872-3674
- [ ] Superior Mobile Medics 1-800-898-3926

- [ ] Long Form
- [ ] EKG

ADDITIONAL INFORMATION

Do you have any reason to believe the policy applied for has replaced or will replace any existing disability insurance coverage? ☐ Yes ☑ No

NOTE: If Yes, fulfill all state requirements.

Has the Notice of Information Practices been provided to the Proposed Insured? ☑ Yes ☐ No

If applying with spouse or business partner, enter name _____

Comments or Special Instructions:

Agent/Producer Signature _____ Date 3/28/17 (Month/Day/Year)

Agent/Producer Signature _____ Date _____ (Month/Day/Year)

56412

EXHIBIT B

APS pg 1--onset: 4/5/17--ceased work: 4/6/17--due to work--no prev treat--no other forms--alsot treat by Dr. Dupree--dx: other spondylosis with radiculopahty lumbar region (Janice Hoden 8/26/2017)

Mutual of Omaha
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

ATTENDING PHYSICIAN'S STATEMENT

CLAIM NUMBER: 584476977900
POLICY NUMBER: 862510-92

1. Insured's Name (First) Harmony (Last) Heffernan Date of Birth [redacted] (Month Day Year)

2. History:

   A. When did symptoms first appear/accident happen? 4 / 5 / 17 (Month / Day / Year)
   Date patient ceased work due to disability: 4 / 6 / 17 (Month / Day / Year)

   B. Has patient ever had same or similar conditions? ☐ Yes ☑ No If Yes, state when and describe

   C. Is condition due to injury or sickness arising out of patient's employment? ☑ Yes ☐ No ☐ Unknown

   D. Is condition due to pregnancy? ☐ Yes ☑ No
   If Yes, Estimated Date of Conception: ___/___/___ (Month / Day / Year)

   E. Have you treated this individual for any other conditions? ☐ Yes ☑ No If Yes, state when and describe:

   F. Have you completed claim forms for other insurance carriers? ☐ Yes ☑ No If Yes, state name of insurance company:

   G. Name and address of other treating physicians or consultants (If none, write none): Dr. Dupree Shrewsbury N.J.

3. Diagnosis:

   A. Primary diagnosis: M47.26 Other spondylosis with radiculopathy lumbar region.
   B. Secondary diagnosis (include complications):
   C. Subjective symptoms: low back pain radiating to lower extremity.
   D. Objective findings: To assist us, we request your cooperation in forwarding: the results of diagnostic tests already taken. For example: electrocardiograms, angiograms, etc., for a heart condition; vital capacity readings for emphysema; x rays for musculoskeletal disorders and the results found through the use of other clinical techniques. For pregnancy, describe any complications.
   Please see attached office visit notes results of MRI's

M20722 Rev 3/17

ECSM-P17042020000900118
08110000000001000

POLICY NUMBER: 862510-92

4. Dates of treatment (include all dates)

A. Office: Date of first visit: 7 / 12 / 17 (Month / Day / Year) Additional dates: 8/4/17 and 8/10/17.

B. Has patient been hospital confined? ☐ Yes ☒ No
If Yes, confined ___/___/___ (Month / Day / Year) to ___/___/___ (Month / Day / Year)

If Yes, name and address of hospital: _____

5. Nature of treatment (include surgery/medication prescribed/physical therapy, if any): patient is currently treating with three different physicians in our office Please see included notes.

6. Extent of disability: Has patient been released to return to work? ☐ Yes ☒ No
If Yes, give date: ___/___/___ (Month / Day / Year)

7. If patient has not been released to return to work, answer A through D.

A. In your opinion, is the patient unable to work in his/her occupation? ☒ Yes ☐ No
If Yes, give dates: 7 / 12 / 17 (Month / Day / Year) to ___/___/___ (Month / Day / Year) TBD.

B. If still unable to work in his or her occupation, when do you expect patient will be able to perform some of his/her work duties?
☒ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ more than 12 months

C. If patient is able to do some work, how long until patient is able to perform all of his/her work duties:
From 7 / 12 / 17 (Month / Day / Year) to ___/___/___ (Month / Day / Year) TBD.

D. What are patient's present limitations? Avoid heavy lifting, bending twisting or any exacerbating activities.

Qasim Husain, MD. (732) 741 2313.
Attending Physician's Name (Please Print) Degree Telephone

80 Oakhill Rd Red Bank NJ 07701
Street Address City State ZIP Code

Signature 8/23/17. [redacted]
Signature Date TIN

APS pg 2: cmpltd 8/23/17 by Qasun Husain MD--1st ov: 7/12/17--add'l treat: 8/4/17, 8/10/17--patient is currently treating with 3 duifferent physicians** unable to work: 7/12/17-unknown--avoid heavy lifting, bending, twisting or any exacerbating activity (Janice Hoden 8/26/2017)**

EXHIBIT C

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

DELIVERY REQUIREMENT

POLICY DELIVERY RECEIPT AND STATEMENT OF GOOD HEALTH (THIS "ADDENDUM")

In further consideration of the issuance and delivery of Policy/Coverage Number: D83D2-862510-92M ("the Policy") to me by Mutual of Omaha Insurance Company ("Mutual of Omaha"), I hereby certify that:

1. I have received the Policy and I have reviewed the Policy and the corresponding application for insurance (the Application). To the best of my knowledge and belief, all answers and statements contained in the Application are true and complete and any amendments and supplements thereto are true and complete as though they were given on the date signed below.
2. Since the date of the Application:
   (a) There has been no change in occupational status from that set forth in the Application;
   (b) To the best of my knowledge and belief, I (a) have had no change in health; (b) have had no illness or injury; and (c) have not consulted a health care provider or been hospitalized since the date of the Application except for any examinations (i.e., medical, paramedical, laboratory) completed at the specific request of Mutual of Omaha; and
   (c) There has been no change in other coverage on myself, issued or applied for, other than as set forth in the Application.

I have read this Addendum and declare that, to the best of my knowledge and belief, the statements made in this Addendum are true and complete. I understand that Mutual of Omaha is relying upon the information set forth in this Addendum and has made execution and delivery of this Addendum a condition of delivery of the Policy.

This Addendum hereby amends the Application as explained above and is attached to and made a part of the Application.

4/11/17
DATE

SIGNATURE OF APPLICANT/POLICYOWNER

SIGNATURE OF PRODUCER

SPECIAL INSTRUCTIONS TO PRODUCER: NO CHANGE TO THE WORDING OF THIS ADDENDUM CAN BE MADE. IF THE APPLICANT/POLICYOWNER, SINCE THE DATE OF THE APPLICATION HAS: (1) A CHANGE IN HEALTH; (2) AN ILLNESS OR HAS BEEN INJURED; OR (3) CONSULTED WITH A HEALTH CARE PROVIDER OR BEEN HOSPITALIZED (OTHER THAN FOR ANY MEDICAL, PARAMEDICAL OR LABORATORY EXAMINATIONS REQUIRED BY MUTUAL OF OMAHA INSURANCE COMPANY), THEN DO NOT DELIVER THE POLICY OR ACCEPT MONEY. INSTEAD, YOU SHOULD IMMEDIATELY CONTACT MUTUAL OF OMAHA INSURANCE COMPANY FOR FURTHER INSTRUCTIONS.

EXHIBIT D

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

04/12/2017

HARMONY B HEFFERNAN
76 ALEXANDER DR
RED BANK NJ 07701

RECORD ADJUSTMENT

In compliance with your request, the following adjustment has been made on the Records of Policy/Certificate Number:

D83D2-862510-92M Effective Date: 04/11/2017

RECORDS ADJUSTED SHOWING ISSUE DATE 04/11/2017 RENEWAL DATE 05/11/2017

MUTUAL OF OMAHA INSURANCE COMPANY

Richard C. Anderl

Corporate Secretary

D5RAR

M3031-NN 1-85

0101300000

EXHIBIT E

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 268 6443
mutualofomaha.com

To: Jan Hoden
(402) 997-1869

BARRY B HEFFERNAN
76 ALEXANDER DR
RED BANK NJ 07701-5530

Pages: 8

Please detach and include in the provided return envelope.

584476977900 862510-92

MUTUAL OF OMAHA INSURANCE COMPANY
ATTN: INDIVIDUAL CLAIMS
3300 MUTUAL OF OMAHA PLZ
OMAHA NE 68175-3100

BARRY B HEFFERNAN
76 ALEXANDER DR
RED BANK NJ 07701-5530

Authorization for Disclosure of Personal Information

(Required by HIPAA and State Laws)

Insured Name: ~~Barry~~ Harmony B Heffernan
Coverage ID: 862510-92
Date of Birth: October 27, 1977
Last 4 of SSN: [redacted]

1. I authorize all hospitals, medical care facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, employers, medical examiners, coroners and other law enforcement officials to disclose Personal Information about the insured to Mutual of Omaha Insurance Company (Mutual of Omaha). The providers authorized to release information include, but are not limited to:
2. Personal Information includes but is not limited to an entire medical record and any other health information concerning the insured (excluding psychotherapy notes), insurance policies and claims, including those containing diagnoses, care or treatments, prescription drug information, alcohol or drug abuse treatment information, or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, admission records, emergency room records, outpatient records, referrals, consults, lab results, office notes, autopsy results, incident and toxicology reports, finances, and occupation.
3. This Personal Information will be used by Mutual of Omaha to evaluate a claim(s) for benefits.
4. This authorization is valid until revoked, or 24 months from the date signed, whichever comes first.
5. I may revoke this authorization at any time by written notice to Mutual of Omaha however revocation will not affect any disclosure of Personal Information that occurred prior to the receipt of my revocation or any action Mutual of Omaha has taken action in reliance on the authorization.
6. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my eligibility for benefits cannot be considered, however my enrollment in the insurance plan will not be affected.
7. I further understand that I have a right to obtain or retain a copy of this authorization and a copy is as valid as the original. I may obtain a copy of this authorization or revoke this authorization by sending written notice to Mutual of Omaha, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
8. I understand that if the person/organization authorized to receive the use of the Personal Information is not a health plan or health care provider covered by federal and state privacy regulations, the Personal Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by these privacy regulations.

[signature] 11/22/17

Signature of Insured/Legal Representative — Date

Harmony Barry Heffernan

Printed Name of Insured/Legal Representative — Type of Legal Representative (Legal Documentation Required)

autho 8/22/17
(Janice Hoden 11/29/2017)

M23333

Authorization for Disclosure of Personal Information

(Required by HIPAA and State Laws)

Insured Name:	Barry B Heffernan	Coverage ID:	862510-92
Date of Birth:	October 27, 1977	Last 4 of SSN:	[redacted]

1. I authorize all hospitals, medical care facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, employers, medical examiners, coroners and other law enforcement officials to disclose Personal Information about the insured to Mutual of Omaha Insurance Company (Mutual of Omaha). The providers authorized to release information include, but are not limited to:
2. Personal Information includes but is not limited to an entire medical record and any other health information concerning the insured (excluding psychotherapy notes), insurance policies and claims, including those containing diagnoses, care or treatments, prescription drug information, alcohol or drug abuse treatment information, or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, admission records, emergency room records, outpatient records, referrals, consults, lab results, office notes, autopsy results, incident and toxicology reports, finances, and occupation.
3. This Personal Information will be used by Mutual of Omaha to evaluate a claim(s) for benefits.
4. This authorization is valid until revoked, or 24 months from the date signed, whichever comes first.
5. I may revoke this authorization at any time by written notice to Mutual of Omaha however revocation will not affect any disclosure of Personal Information that occurred prior to the receipt of my revocation or any action Mutual of Omaha has taken action in reliance on the authorization.
6. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my eligibility for benefits cannot be considered, however my enrollment in the insurance plan will not be affected.
7. I further understand that I have a right to obtain or retain a copy of this authorization and a copy is as valid as the original. I may obtain a copy of this authorization or revoke this authorization by sending written notice to Mutual of Omaha, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
8. I understand that if the person/organization authorized to receive the use of the Personal Information is not a health plan or health care provider covered by federal and state privacy regulations, the Personal Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by these privacy regulations.

H. B H

Signature of Insured/Legal Representative

11/22/17

Date

Harmony Barry Heffernan

Printed Name of Insured/Legal Representative

Type of Legal Representative
(Legal Documentation Required)

M23333

MUTUAL of OMAHA INSURANCE COMPANY
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

occ duties: maintenance man--cargo shipping company--40 hrs/wk--3 yrs w/ emplyr--10 yrs in occ--medium lifting--1 yr cllg (Janice Hoden 11/29/2017)

INSURED'S OCCUPATIONAL DESCRIPTION

Claim Number 584476977900
Policy Number: 862510-92

1. Insured's Name Harmony (First) Heffernan (Last) Date of Birth [redacted] (Month Day Year)
2. Job title(s): Maintenca man
3. Nature of employer's business Cargo shipping company
4. Number of hours worked in a normal week: 40 Years with employer 30 Years in occupation 10
5. List the duties of your occupation(s) in order of their importance, with a detailed description of each:
   Duty Check oil levels + Fluid Hours spent each week 40
   Description Inspect machinery to be sure engine works properly
   Duty Fill Coolants, lubricate wear point Hours spent each week _____
   Description Check any + all functions on machine
6. If your occupation includes lifting, please indicate extent according to the following classifications (circle one letter):
   A. Sedentary — Involves sitting, walking and standing. Objects lifted weight between zero and 10 pounds.
   B Light — Involves frequently lifting and carrying of objects weighing between 10 and 20 pounds and jobs which require significant walking and/or standing.
   (C. Medium) — Involves lifting between 25 and 50 pounds.
   D. Heavy — Involves lifting between 50 and 100 pounds.
   E. Very Heavy — Involves lifting over 100 pounds.
7. How has your disability interfered with the performance of the job? Please describe sitting, standing, and walking requirements and limitations: NONE
8. Previous employment:

Occupational Title	Employers Name	Dates Employed
~~Tribar Services Inc~~ Vice president	Tribar Services	2007 - 2014

9. Indicate your highest level of education completed: College: # of years completed 1 High School: # of years completed ____ Grade School: # of years completed _____
   Please specify degree(s), diploma(s), or certificate(s) and area of concentration:

Date 11/22, 2017 Insured's signature [signature]

M20374 Rev. 3/17

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

po proof pg 1: mantenance--APM Terminals--emplyr does not pay prem--$240,000/yr--hernia--no dates or phys info (Janice Hoden 11/29/2017)

INSURED'S STATEMENT FOR DISABILITY BENEFITS **ANSWER ALL QUESTIONS THAT APPLY**

POLICY NUMBER: 862510-92 **Claim Number** 584476977900

1. Insured's Name (First) Harmony (Last) Heffernan Date of Birth [redacted]
   Insured's Address (Street) 76 Alexander Dr. (City) Red bank (State) NJ (Zip Code) 07701
   Social Security Number [redacted] Telephone Number (732) 747 - 0486
   Policy Number 862510-92 Life Policy Number _____
2. Employer Name APM Terminals Telephone Number (908) _____
   Employer Address (Street) 5080 McLester St. (City) Elizabeth (State) NJ. (Zip Code) _____
3. If you are considered an employee or if you are self-employed and your business is incorporated, does your employer pay any portion of the insurance premium for your disability coverage with our company?
   Yes____ No✓ If Yes, what percentage? _____%
4. What is your occupation? Maintence
5. What was your annual income prior to disability? 240,000 per year
6. What sickness or injury was suffered? hernia
7. What date did the sickness or injury happen? If an accident, describe how/where it happened. _____
8. What date were you first treated by a physician for this sickness or injury? _____
9. Were you confined in a hospital for this sickness or injury? Yes___ No✓ If Yes, give name of Hospital and Dates of Confinement. _____
10. Has any other physician treated you for this condition? Yes___ No___ If Yes, when? _____
    Physician Name and Address _____
11. Have you had the same kind of sickness or injury before? Yes___ No✓ If Yes, when? _____
    Physician Name and Address _____
12. Have you had any medical or surgical advice during the past five years for any other condition? Yes____ No____
    What was the condition? Dates of Treatment _____
    Physician's Name and Address _____

M20740 Rev. 3/17

POLICY NUMBER: 862510-92

Hospitalized? Yes____ No ✓ If Yes, provide Dates of Confinement_____

Hospital Name and Address_____

13. Dates unable to work for current period of disability: ____/____/____ (Month Day Year) to ____/____/____ (Month Day Year)

14. What was your last day worked prior to disability? 4/5/17 (Month Day Year)

15. Date returned to work in a limited capacity: ____/____/____ (Month Day Year) to ____/____/____ (Month Day Year)

16. Date returned to work full time: 9/11/17 (Month Day Year)

17. If pregnancy is involved: Expected date of delivery: ____/____/____ (Month Day Year)

Exact date of delivery: ____/____/____ (Month Day Year) Expected return to work date: ____/____/____ (Month Day Year)

Please indicate the type of delivery and any complications:_____

18. Please check any and all benefits that you are eligible to receive:

	Applied Y/N	Date Applied	Amount Receiving	Date Benefits Began
A. Social Security				
B. Worker's Compensation				
C. State Disability Insurance				
D. Retirement or Pension				
E. Short Term Disability				
F. Salary Continuation				
G. Unemployment				
H. Union				
I. Medicare/Medicaid				

Describe all insurance coverage in force: (A) Individual; (B) Group; (C) Salary Continuance; (D) Disability/Overhead Expense; (E) Hospital/Medical Coverage: **If none, so state by writing "none".**

Company or Source	Type (A, B, C, D, E)	Monthly Amount	Benefit Period	Elimination Period

As part of our claim procedure, a consumer report may be secured through personal interviews with third parties, which may include information as to your character, reputation, mode of living, etc. You have the right to make written request within a reasonable period of time concerning the nature and scope of this investigation.

Date 11/22, 2017 Insured's Signature [signature]

M20740 Rev. 3/17

po proof pg 2: cmpltd 11/22/17--last dy wrkd: 4/5/17--no dates of disab--rtw full time 9/11/17--no other ins or bens
(Janice Hoden 11/29/2017)

Mutual of Omaha

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

EMPLOYER'S STATEMENT FOR DISABILITY BENEFITS

Policy Number: 862510-92 Claim Number: 584476977900

1. Insured's Name Harmony (First) Heffernan (Last) Date of Birth: [redacted] (Month Day Year)

2. Date employed: June (Month) 9 (Day) 2014 (Year)

3. Claimant is: (X) Full-time ( ) Part-time # of hours worked per week: _____

4. Is claimant retired: ( ) Yes (X) No Retirement date: ____/____/____ (Month Day Year)

5. Claimant's salary immediately prior to date last worked: Amount $4,500
(Check one) (X) Weekly ( ) Monthly ( ) Annually

6. How long was claimant at this salary? 6 (Month) / 9 (Day) / 14 (Year) to 4 (Month) / 5 (Day) / 17 (Year)

7. Date claimant last worked: 4 (Month) / 5 (Day) / 17 (Year)

8. Initial date of total disability: (Usually one day after date last worked.) 4 (Month) / 10 (Day) / 17 (Year)
Any difference should be explained in REMARKS.

9. Is claimant's job being held open? (X) Yes ( ) No_____ If No, please explain

_____

10. If employment terminated, give date: ____/____/____ (Month Day Year)
If necessary, please use REMARKS to explain circumstances.

11. Could accommodations be made to enable claimant to return to work? (X) Yes ( ) No

If No, please explain in REMARKS.

employer statement pg 1: date emplyd: 6/9/14 full time $4500/wk--last day worked: 4/5/17--disab: 4/10/17--job held open, accommodations could be made (Janice Hoden 11/29/2017)

M20392 Rev. 3/17

ECSM-P170420200090001180511000000000001000

Policy Number: 862510-92

12. Has claimant returned to work: Full Time: (✓) Yes ( ) No If Yes, on what date? 9 / 11 / 17 (Month / Day / Year)

Part Time/Light Duty: ( ) Yes ( ) No If Yes, on what date? ___/___/___ (Month / Day / Year)
(Please provide details of part time or light duties in REMARKS.)

If No, when do you expect claimant to resume work? ___/___/___ (Month / Day / Year)

A. Is claimant receiving or entitled to any weekly or monthly disability benefits? ( ) Yes (✓) No

If Yes, give amounts and how long claimant is eligible: _____

B. Is claimant receiving or entitled to any pension or retirement benefits? ( ) Yes (✓) No

If Yes, give amounts: _____

C. Is claimant receiving or entitled to any Worker's Compensation/Employer Liability Benefits?
( ) Yes (✓) No

If Yes, give amounts: _____

D. Do you pay any portion of the claimant's Mutual of Omaha coverage premium? ( ) Yes (✓) No

If Yes, what percent? _____

E. Please provide a description of the claimant's job duties Maintenance

F. REMARKS: _____

Employer's Information:

Terri Schaeffer (Employer's Signature) — On behalf of CT TPA APM Terminals (Company Name)

64 Danbury Street. Ste. 201 (Mailing Address) — Wilton (City) — CT (State) — 06897 (ZIP Code) — 203-210-1610 (Telephone Number)

Individual to contact if necessary (please print):

Terri Schaeffer (Name) — VP-Northeast (Title) — 203-210-1610 (Telephone Number)

M20392 Rev. 3/17

emplyr stmnt pg 2: empltd by Terri Schaeffer--Northeast--CT TPA APM Terminals--RTW 9/11/17--no emplyr bens, does not pay prem (Janice Hoden 11/29/2017)

EXHIBIT F

Uram, Thomas

From: Melissa.Holm@mutualofomaha.com
Sent: Friday, August 09, 2019 5:42 PM
To: Uram, Thomas
Subject: [EXTERNAL] RE: Harmony B. Heffernan SIU #201800568 Policy #862510-92 Claim # 584476977900

Hi, Investigator Uram.
In regards to your question, I have requested the Chief Underwriter to address. Her response is as follows:

If Mr. Heffernan had disclosed on the Statement of Good Health that was signed on 4/11/17 that he had an injury on 4/5/17 and went on disability 4/6/17, the policy would not have been issued.

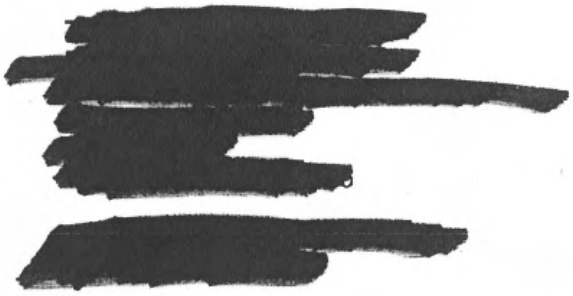
Should the case move forward, I should be available to testify but would appreciate your offer to discuss details by phone. I should be in the office most of next week and will await your call.
Have a nice weekend!

Melissa Holm x5431
Sr. Corporate Investigator
11 - Corporate Investigations
Compliance & Ethics
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175

Phone: 402.351.5431 or 800.877.6860 x5431
Fax 402.351-1456

Mutual Confidential

[redacted]



PLEASE NOTE: Effective July 30, 2019, my new phone number will be 609-940-7711

EXHIBIT G

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175
1 800 268 6443
mutualofomaha.com

April 6, 2018

HARMONY B HEFFERNAN
76 ALEXANDER DR
RED BANK NJ 07701-5530

Claim Number: 584476977900
Policy Number: 862510-92

Dear Mr. Heffernan:

We have completed our review of your claim for disability benefits.

Enclosed is a photocopy of your policy application singed by you on March 28, 2017 and the Policy Delivery Receipt and Statement of Good Health form signed by you on April 11, 2017.

Before an insurance policy can be issued, it is necessary that a formal application be completed. The information contained in this application is most important in determining if an applicant is eligible for coverage. When your policy was delivered to you, you were asked to sign the Policy Delivery Receipt and Statement of Good Health form. This was an opportunity to review the application for correctness and notify the Company of any errors, omissions or changes that occurred since signing the application.

Based on the answers given to the questions on the application and your signature on the Policy Delivery Receipt and Statement of Good Health form attesting that there had been no changes to your occupational status or health and you had no illness or injury or consulted a health care provider from the date of the application on March 28, 2017 to the date you signed the Policy Delivery Receipt and Statement of Good Health form on April 11, 2017, your policy was issued effective April 11, 2017.

In the process of developing your claim, we received the claim forms completed by you and your employer documenting your last day worked was April 5, 2017 and you returned to work in full capacity September 11, 2017.

The Attending Physician's Statement completed by Qasim Husain MD documents you had an injury at work on April 5, 2017 and ceased working April 6, 2017. The diagnosis documented as the cause of your disability was Other Spondylosis with Radiculopathy Lumbar Region.

Medical records obtained from Orthopedic Sports Medicine and Rehabilitation Center document you had a work related injury on April 5, 2017 suffering a right foot injury and back injury.

The information on the claim forms and in the medical records directly contradict your signature on the Policy Delivery Receipt and Statement of Good Health form signed by you on April 11, 2017 attesting that there had been no changes to your occupational status or health and you had no illness or injury or consulted a health care provider from the date of the application on March 28, 2017 to the date you signed the Policy Delivery Receipt and Statement of Good Health form on April 11, 2017.

If this information had been shown at the time you signed the Policy Delivery Receipt and Statement of Good Health form on April 11, 2017, your policy would not have been issued in its present form. Now that we have the information, it is necessary for us to take the same action as would have been taken if the full facts had been disclosed to us at the time you applied for this policy.

As a result of this non-disclosure of the above condition your contract is being rescinded. This means it is considered to have never been in force as of the issue date. A full refund of premiums paid will be sent under separate cover. If any additional premium is received, it will also be refunded. Benefits are not payable for any claims presented under this policy.

This decision is based on available information. If you have any additional information related to this matter, please send it to us for further consideration.

Mutual of Omaha fully reserves all rights which arise under the policy, and nothing set forth herein is intended to be a waiver or limitation of the company's rights.

Our decision is based on the information in file. If you would like to submit any additional information in support of this request for benefits, please feel free to do so. We would be glad to review any additional information.

Please sign and date the enclosed letter acknowledging your acceptance of this decision.

If you have any questions, please call (402) 351-2861. All formal appeals must be submitted in writing.

Sincerely,

Jan Hoden

Jan Hoden
LTD Claims Analyst
Individual LTD/CI/Accident Claims

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY
Richard J. Hughes Justice Complex
25 Market Street
P.O. Box 117
Trenton, New Jersey 08625-0117
Attorney for Plaintiff

By: Brian R. Fitzgerald
Deputy Attorney General
NJ Attorney ID No. 024972004
(609)376-2965
brian.fitzgerald@law.njoag.gov

SUPERIOR COURT OF NEW JERSEY
SPECIAL CIVIL PART - MONMOUTH COUNTY
DOCKET NO. MON-DC-006241-19

MARLENE CARIDE, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiff, v. HARMONY B. HEFFERNAN, Defendant.	**Civil Action** **ORDER FOR SUMMARY JUDGMENT**

This matter coming before the Court on the application of Gurbir S. Grewal, Attorney General of New Jersey, by Brian R. Fitzgerald, Deputy Attorney General, attorney for the Plaintiff, Marlene Caride, the Commissioner of the New Jersey Department of Banking and Insurance ("Plaintiff"), for an Order of Summary Judgment against the Defendant, Harmony B. Heffernan

("Defendant"), and the Court having considered the papers submitted by counsel, and for good cause shown;

It is on this day of , 2019:

ORDERED that Summary Judgment be and is hereby **GRANTED** in favor of Plaintiff against Defendant; and

IT IS FURTHER ORDERED that Defendant is adjudged liable for one violation of N.J.S.A. 17:33A-1 to -30, the New Jersey Insurance Fraud Prevention Act, specifically N.J.S.A. 17:33A-4(a)(4)(b), for making a written statement intended to be presented to an insurance company for the purpose of obtaining an insurance policy knowing that the statement contained false or misleading information about facts material to the insurance application; and

IT IS FURTHER ORDERED that judgment be and is hereby entered against Defendant in the amount of $8,860.00, which consists of a civil penalty in the amount of $5,000.00 pursuant to N.J.S.A. 17:33A-5(b); attorney's fees in the amount of $2,860.00 pursuant to N.J.S.A. 17:33A-5(b); and a $1,000.00 surcharge pursuant to N.J.S.A. 17:33A-5.1.

_____
Hon. Daniel L. Weiss, J.S.C.

_____ opposed

_____ unopposed

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

State of New Jersey
OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF LAW
25 MARKET STREET
PO Box 117
TRENTON, NJ 08625-0117

GURBIR S. GREWAL
Attorney General

MICHELLE L. MILLER
Director

August 21, 2019

VIA eCOURTS AND REGULAR MAIL

Hon. Daniel L. Weiss
Monmouth County Courthouse
Special Civil Part
71 Monument Park
P.O. Box 1270
Freehold, NJ 07728

Re: Marlene Caride, Commissioner of the New Jersey Department of Banking & Insurance v. Heffernan, Docket NO. MON-DC-006241-19

Dear Judge Weiss:

Please accept this letter in lieu of more formal brief in support of the Motion for Summary Judgment filed by Plaintiff, Marlene Caride, Commissioner of the New Jersey Department of Banking and Insurance ("Commissioner"), pursuant to R. 6:6-1 and R. 4:46 against the defendant, Harmony B. Heffernan ("Defendant").

PRELIMINARY STATEMENT

This is a civil enforcement action brought by the Commissioner

against Defendant pursuant to the New Jersey Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 to -30 ("Fraud Act"). The undisputed material facts will show that, Defendant violated N.J.S.A. 17:33A-4(a)(4)(b) of the Fraud Act by making a written statement intended to be presented to an insurance company for the purpose of obtaining an insurance policy, knowing that the statement contained false or misleading information about facts material to the insurance application. Specifically, in connection with applying for an individual disability insurance policy from Mutual of Omaha Insurance Company ("Mutual of Omaha"), Defendant knowingly submitted documentation to Mutual of Omaha misrepresenting that he had not been injured between the time he applied for the policy and the issuance of the policy. When Mutual of Omaha discovered the misrepresentation, it rescinded the policy. Accordingly, the Commissioner is entitled to judgment under the Fraud Act consisting of civil penalties, attorneys' fees, and statutory surcharge.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. On March 28, 2017, Defendant applied to Mutual of Omaha for an individual disability insurance policy. Certification of Thomas Uram ("Uram Cert"), ¶ 1, Ex. A.

2. On April 5, 2017, Defendant was injured at his place of employment. Id., ¶ 2, Ex. B. See also id., ¶ 6, Ex. E.

3. On April 6, 2017, Defendant ceased working due to disability. Id., ¶ 3, Ex. B. See also id., ¶ 6, Ex. E.

4. On April 11, in order to obtain the individual disability insurance policy, and as a prerequisite for the policy to be effective, Defendant signed a "Policy Delivery Receipt and Statement of Good Health" ("Statement of Good Health"), representing, among other things, that between the application date, March 28, 2017, and the effective date of the policy, that: there had been no change in Defendant's occupational status; there had been no change in Defendant's health; and Defendant had not suffered any illness or injury. Id., ¶ 4, Ex. C.

5. On April 12, 2017, the policy was issued with an effective date of April 11, 2017. Id., ¶ 5, Ex. D.

6. On or about November 22, 2017, Defendant filed a claim for disability benefits. In the documentation Defendant submitted to Mutual of Omaha in support of his claim, Defendant disclosed that he was injured on April 5, 2017. Id., ¶ 6, Ex. E.

7. Had Defendant disclosed his injury and change in occupational status on the Statement of Good Health, Mutual of

Omaha would not have issued the policy. Id., ¶ 7, Ex. F.

8. Mutual of Omaha rescinded the policy on April 6, 2018 due to Defendant's misrepresentations. Id., ¶ 8, Ex. G.

LEGAL ARGUMENT

THE COMMISSIONER IS ENTITLED TO SUMMARY JUDGMENT AS A MATTER OF LAW FOR CIVIL PENALTIES, ATTORNEYS' FEES AND SURCHARGE UNDER THE FRAUD ACT

The undisputed material facts entitle the Commissioner to judgment as a matter of law under the Fraud Act. Summary judgment is an expeditious way to resolve litigation in a "prompt, businesslike and inexpensive" manner. Brill v. Guardian Life Ins. Co., 142 N.J. 520, 530 (1995) (quoting Ledley v. William Penn Life Ins. Co., 138 N.J. 627, 641-42 (1995) (internal citations omitted)). The Supreme Court has warned that "[t]o send the case to trial knowing that a rational [fact-finder] can reach but one conclusion, is indeed worthless and will serve no useful purpose." Brill, 142 N.J. at 540. Rather, "[w]hen the evidence is so one-sided that one party must prevail as a matter of law, the trial court should not hesitate to grant summary judgment." Ibid.

Here, the undisputed material facts demonstrate that Defendant knowingly failed to disclose his April 5, 2017 injury to Mutual of Omaha on the Statement of Good Health, thereby knowingly

misrepresenting that he had not been injured between the date of the insurance application (March 28, 2017) and the date the policy became effective (April 11, 2017). Accordingly, the court should grant summary judgment in favor of the Commissioner.

A. Defendant Violated N.J.S.A. 17:33A-4(a)(4)(b) by Knowingly Submitting False Material Information in Support of the Individual Disability Insurance Application.

Section 4(a)(4)(b) of the Fraud Act provides that a "person or practitioner violates this act" if he:

> Prepares or makes any written or oral statement, intended to be presented to any insurance company or producer for the purpose of obtaining [a]n insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract.
>
> N.J.S.A. 17:33A-4(a)(4)(b).

Here, the undisputed material facts establish that Defendant knowingly misrepresented to Mutual of Omaha on the Statement of Good Health that he had not been injured between the date of the insurance application and the date the insurance policy became effective. Indeed, Defendant's liability under N.J.S.A. 17:33A-4(a)(4)(b) is clearly established by documents that Defendant himself submitted in support of a claim for disability benefits. Uram Cert., ¶ 6, Ex. E.

B. Judgment Should Be Entered Against the Defendant for an Assessment of Civil Penalties, Attorneys' Fees, and Surcharge as Provided for in the Fraud Act.

The Fraud Act provides for penalties "of not more than $5,000 for the first violation, $10,000 for the second violation and $15,000 for each subsequent violation." N.J.S.A. 17:33A-5(b). Additionally, any person who is found in any legal proceeding to have committed insurance fraud shall be subject to a surcharge in the amount of $1,000.00. N.J.S.A. 17:33A-5.1. Moreover, "[t]he court shall also award costs and reasonable attorneys' fees to the commissioner." N.J.S.A. 17:33A-5(b) (emphasis added).

Here, the Commissioner is requesting a civil penalty for one violation of the Fraud Act based on Defendant's knowing misrepresentation to Mutual of Omaha that he had not been injured between the time he applied to Mutual of Omaha for an individual disability insurance policy and the effective date of the policy. In addition to the $5,000 civil penalty, the Commissioner is also requesting reasonable attorneys' fees of $2,860.00 and the mandatory $1,000.00 surcharge. (See Fee Certification of Brian R. Fitzgerald.)

C. The Kimmelman Factors Weigh in Favor of a Civil Penalty

Although it is mandatory for the Court to award civil

penalties for violations of the Fraud Act, the Fraud Act provides for an amount "up to $5,000" for each violation of the Fraud Act. N.J.S.A. 17:33A-5(b). The factors set forth in Kimmelman v. Henkels & McCoy, Inc., 108 N.J. 123 (1987) ("Kimmelman Factors") should be used by the Court to determine the appropriate penalty amount. Id. at 137-139. Under Kimmelman, the Court should consider: (1) the amount of profits likely to be obtained from the illegal activity; (2) the good or bad faith of defendant; (3) defendant's ability to pay; (4) injury to the public; (5) duration of the conspiracy; (6) existence of criminal or treble damages action; and (7) past violations. Ibid.

With respect to the first factor, Defendant attempted to receive disability benefits including lost income of $4,500.00 per week plus medical benefits. (See Uram Cert., ¶ 6, Ex. E.) A significant penalty is warranted to deter Defendant and the public at large from attempts to fraudulently obtain insurance policies and benefits. Accordingly, this factor weighs in favor of the $5,000.00 penalty.

With respect to the second factor, Defendant acted in bad faith because he knowingly misrepresented that he had not been injured between the time of his insurance application and the time

he signed the Statement of Good Health (see Uram Cert. ¶¶ 1 - 6), and once Mutual of Omaha learned of the misrepresentation, it rescinded Defendant's policy. This weighs in favor of a greater penalty because Defendant knowingly tried to defraud Mutual of Omaha.

With respect to the third factor, Defendant's ability to pay is unknown. Thus, this factor is neutral.

With respect to the fourth factor, Defendant's violation of the Fraud Act constitutes injury to the public because he attempted to obtain disability benefits that would otherwise be used for legitimate claims. The Fraud Act is a remedial statute, and its purpose is to "confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims." N.J.S.A. 17:33A-2. Specifically, the purpose of the civil penalties serve to "compensate the State for the costs incurred as a result of investigating and prosecuting insurance fraud." Liberty Mutual Insurance Co. v. Land, 186 N.J. 163 at 174 (2006) (citing Merin v.

Maglaki, 126 N.J. at 445 (1991)). Here, Defendant's misrepresentations to Mutual of Omaha in connection with his application for disability insurance caused the State to exert time and money to investigate his fraudulent act. The State is not required to provide precise calculations to support the penalty imposed. Merin, 126 N.J. at 445 ("For the State to provide precise calculations of the costs associated with investigating and prosecuting a particular attempted insurance fraud would be difficult, if not impossible"). Further, there is a strong public policy in New Jersey to deter insurance fraud, which harms the citizens of this State in the form of higher premiums. Selective Ins. Co. of Am. V. Hudson East Pain Mgmt., 416 N.J. Super. 418, 432 (App. Div. 2010) ("To be sure, our State has a strong public interest in deterring insurance fraud. The State's high insurance rates are, in part, the result of fraudulent claims and practices.")

With respect to the fifth factor, the conduct was a single occurrence, weighing in favor of a lesser penalty.

With respect to the sixth factor, the fact that there has been no criminal action against Defendant for his conduct means a larger civil penalty is not unduly punitive.

Finally, with respect to the seventh factor, to the best of the Commissioner's knowledge, there are no past violations of the Fraud Act by Defendant. Therefore, this factor does not suggest a larger penalty.

Based on the foregoing, the Kimmelman Factors suggests that the imposition of the maximum penalty of $5,000.00 is warranted.

CONCLUSION

For all the foregoing reasons, the Commissioner's Motion for Summary should be granted in all respects.

Respectfully Submitted,

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY

By: _____
Brian R. Fitzgerald
Deputy Attorney General

c: Mr. Harmony B. Heffernan (via certified mail r/r/r and regular mail)

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY
Richard J. Hughes Justice Complex
25 Market Street
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Trenton, New Jersey 08625-0117
Attorney for Plaintiff

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SUPERIOR COURT OF NEW JERSEY
SPECIAL CIVIL PART - MONMOUTH COUNTY
DOCKET NO. MON-DC-006241-19

MARLENE CARIDE, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE,

Plaintiff,

v.

HARMONY B. HEFFERNAN,

Defendant.

Civil Action

CERTIFICATION OF SERVICE

I, Brian R. Fitzgerald, Deputy Attorney General and counsel for the Plaintiff, Marlene Caride, Commissioner of the New Jersey Department of Banking and Insurance ("Plaintiff"), in the above-captioned matter, hereby certify that copies of the foregoing (a) Notice of Motion for Summary Judgment; (b) letter brief in support of Plaintiff's Motion for Summary Judgment; (c) Fee Certification

of Brian R. Fitzgerald (with accompanying exhibits); (d) Certification of Thomas D. Uram (with accompanying exhibits); and (e) proposed Order of Summary Judgment, were duly served on the Defendant, Harmony B. Heffernan ("Defendant") by sending copies by both certified mail return receipt requested and regular mail to Defendant at the following address:

76 Alexander Drive
Red Bank, NJ 07701

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

By: _____
Brian R. Fitzgerald

Dated: August 21, 2019

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY
Attorney for Plaintiff
Richard J. Hughes Justice Complex
25 Market Street
P. O. Box 117
Trenton, New Jersey 08625-0117

By: Brian R. Fitzgerald
Deputy Attorney General
NJ Attorney ID: 024972004
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SUPERIOR COURT OF NEW JERSEY
SPECIAL CIVIL PART - MONMOUTH COUNTY
DOCKET NO. MON-DC-006241-19

MARLENE CARIDE, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE, Plaintiff, v. HARMONY B. HEFFERNAN, Defendant.	Civil Action **FEE CERTIFICATION OF BRIAN R. FITZGERALD**

I, Brian R. Fitzgerald, of full age, do of my own personal knowledge hereby certify and say in lieu of affidavit pursuant to R. 1:4-4(b):

1. I am the Deputy Attorney General assigned to represent Plaintiff, Marlene Caride, Commissioner of the New Jersey Department of Banking and Insurance, Bureau of Fraud Deterrence ("Plaintiff") in the above-captioned matter. I am fully

familiar with the facts set forth herein. I make this Certification in support of Plaintiff's Motion for Summary Judgment against Defendant Harmony B. Heffernan ("Defendant").

2. This Certification is submitted in support of Plaintiff's request for attorney's fees in the above action, charging one violation of the Insurance Fraud Prevention Act ("Fraud Act"), N.J.S.A. 17:33A-1 to -30, against Defendant.

3. Reasonable attorneys' fees and costs are mandated by the Fraud Act. N.J.S.A. 17:33A-5(b). The New Jersey Department of Law and Public Safety, Division of Law ("DOL") has established a Schedule of Attorneys' Fees that provides a uniform hourly rate of compensation for DOL legal staff. (A true and exact copy of this schedule is attached as Exhibit 1.)

4. DOL legal staff complete daily time sheets which document the legal services performed. For each matter, the DOL timekeeping system requires the activity date, an activity code, and the time spent for each particular activity. The client activity codes are designated as follows:

CAD - Administration
CAP - Appearance
CCM - Conference/Meeting/ Telephone
CCR - Correspondence
CDR - Contract/Document Review
CDS - Discovery
CIV - Investigation
CMB - Motion/Brief
CMS - Miscellaneous
CPR - Prep Trial/Hearing/ Argument
CRW - Research/Writing
CSP - Supervision
CTL - Travel

5. I have reviewed timekeeping records and documentation in the file to determine the amount of time expended by myself and other DOL legal staff on the matter. Plaintiff is seeking compensation for the legal services provided by Nicholas Kant, Assistant Section Chief/Deputy Attorney General, and myself.

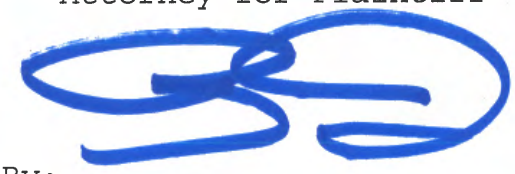
6. As attorneys with eleven (11) to twenty (20) years of legal experience, the hourly rate of compensation for Assistant Section Chief Kant and Deputy Attorney General Fitzgerald is $260.00 per hour.

7. Assistant Section Chief Kant spent a total of 2.3 hours in the supervision of this matter. I spent a total of 8.7 hours in the review, preparation, and prosecution of this matter, including drafting the Complaint and Motion for Summary Judgment and accompanying certifications. Accordingly, the Commissioner seeks compensation for all of the time spent on this matter, for a total of $2,860.00 in legal services. (A true and exact copy of the timekeeping statements for these services is attached as Exhibit 2.)

8. Plaintiff reserves the right to further supplement the certification.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

GURBIR S. GREWAL
ATTORNEY GENERAL OF NEW JERSEY
Attorney for Plaintiff



By: _____
Brian R. Fitzgerald
Deputy Attorney General

Dated: August 21, 2019

EXHIBIT 1

SCHEDULE OF ATTORNEY FEES
HOURLY RATE OF COMPENSATION FOR LEGAL STAFF

Michelle L. Miller, Acting Director, Division of Law has determined that effective September 1, 2015, the uniform rate of compensation in cases where the State is entitled to recovery of fees be and hereby is amended as follows:

PARALEGAL .....$75 per hour

LAW ASSISTANT .....$150 per hour

DEPUTY ATTORNEY GENERAL .....$200 per hour
(0-5 years of legal experience)

DEPUTY ATTORNEY GENERAL .....$235 per hour
(6-10 years of experience)

DEPUTY/ASSISTANT ATTORNEY GENERAL .....$260 per hour
(11-20 years of experience)

DEPUTY/ASSISTANT ATTORNEY GENERAL .....$300 per hour
(more than 20 years of experience)

EXHIBIT 2

TK_INFOMAT

08/13/2019

DIVISION OF LAW TIMEKEEPING SYSTEM
INFORMATION FOR ONE MATTER
FOR THE PERIOD 01/01/2019 TO 08/12/2019

MATTER NUMBER: 19-00971
MATTER NAME: HEFFERNAN, HARMONY - BFD #18-52551

	TIME
FITZGERALD, BRIAN	8.7
KANT, NICHOLAS	2.3
MATTER TOTAL:	**11.0**

DIVISION OF LAW TIMEKEEPING SYSTEM
TIMESHEET REPORT
FOR THE PERIOD 01/01/2019 TO 08/12/2019

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 04/12/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH DEFENDANT		
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		
CMS	.7	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVIEW INVESTIGATIVE REPORTS AND EXHIBITS		

TOTAL: **.9**

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 04/15/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.3	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVIEW INVESTIGATIVE REPORTS AND EXHIBITS IN PREPARATION FOR DRAFTING COMPLAINT		
CAD	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CALL WITH INVESTIGATOR		
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		

DIVISION OF LAW TIMEKEEPING SYSTEM
TIMESHEET REPORT
FOR THE PERIOD 01/01/2019 TO 08/12/2019

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 04/15/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	1.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	DRAFT COMPLAINT AND MEMO		

TOTAL: **2.0**

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 04/16/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		

TOTAL: **.1**

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 05/23/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	WORK ON COMPLAINT		

TOTAL: **.1**

DIVISION OF LAW TIMEKEEPING SYSTEM
TIMESHEET REPORT
FOR THE PERIOD 01/01/2019 TO 08/12/2019

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 05/24/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVISE COMPLAINT AND MEMO		

TOTAL: .4

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 05/28/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		

TOTAL: .2

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 05/29/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCM	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CALL WITH INVESTIGATOR		

TOTAL: .1

DIVISION OF LAW TIMEKEEPING SYSTEM
TIMESHEET REPORT
FOR THE PERIOD 01/01/2019 TO 08/12/2019

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 05/31/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		
CMS	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVISE COMPLAINT AND MEMO		

TOTAL: **.5**

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 06/03/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	WORK ON COMPLAINT AND MEMO		
CCM	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CALL WITH INVESTIGATOR		
CCM	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CONFER WITH N. KANT		
CCR	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH INVESTIGATOR		

TOTAL: **1.2**

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 06/05/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVISE COMPLAINT AND MEMO		

TOTAL: .4

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 06/24/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.4	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVISE COMPLAINT AND MEMO		

TOTAL: .4

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 06/26/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CMS	.3	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVISE COMPLAINT AND PREPARE FOR FILING		
CMS	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	FILED COMPLAINT		

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 06/26/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH R. BESSER ET AL.		
CCM	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CONFER WITH N. KANT		

TOTAL: .6

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 08/05/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCM	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CALL WITH DEFENDANT		

TOTAL: .1

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 08/06/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CORR WITH PARALEGAL		

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 08/06/2019

TOTAL: .1

DAG: 825 FITZGERALD, BRIAN **ACT DATE:** 08/08/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CDS	.9	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	PREPARE DISCOVERY REQUESTS TO HEFFERNAN		
CCM	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CALL WITH HEFFERNAN		
CCM	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	CONFER WITH N. KANT		
CCR	.1	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	DRAFT LETTER TO HEFFERNAN RE: NEW TRIAL DATE		
CCR	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	DRAFT LETTER TO HEFFERNAN		
CCR	.2	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	DRAFT LETTER TO COURT		

TOTAL: 1.6

DAG: Z28 KANT, NICHOLAS **ACT DATE:** 05/23/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CDR	.9	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVIEW COMPLAINT		

TOTAL: .9

DAG: Z28 KANT, NICHOLAS **ACT DATE:** 05/24/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CDR	.5	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVIEW COMPLAINT		

TOTAL: .5

DAG: Z28 KANT, NICHOLAS **ACT DATE:** 06/21/2019

ACT CODE	TIME	MATTER	MATTER NAME	BILL CODE	BILL SUBCODE
CDR	.9	19-00971	HEFFERNAN, HARMONY - BFD #18-52551	OFP	
		DESC:	REVIEW COMPLAINT		

TOTAL: .9

MATTER TOTAL: 11