

United
Southern District of Texas
FILED

OCT 15 2025

Nathan Ochsner, Clerk of Court

10-9-25

Honorable Christopher Lopez

Dear Sir/Madam Clerk,

I need a proof of claim form to send to the "Trust", I do not understand why I did not receive one because I received all the other correspondences and I filed a motion to be added to the suit. I have been in litigation for over a year with this process. *Attention, please be advised that I am sight/vision impaired under the ADA so please send me any necessary forms. Also, enclosed is a copy of the correspondence. I need a file check done at your earliest convenience so that I can make the trust cause they already have all of my medical discharges and the "Trust's" submission form. I appreciate your time and immediate attention in this matter.

PS. I need a "410" Form.

Respectfully Submitted,
Renard McClain

239008625101600000000001

Honorable Christopher Lopez 11-4-24
U.S. Bankruptcy Court for Texas
515 Rusk, Courtroom 401
Houston, Texas 77002

Under A.D.A., Renard McClain
217-269sid/300894
18701 Roxbury Road
Hagerstown, Md. 21746

Subject: Unsecured Creditor
Re: Chapter 11
Case No. 23-90086 (CML)
Related Dkt. Nos. 1740 & 1741

Dear Judge Lopez,

I am an "Unsecured Claimant" in the above captioned case, I filed a Motion to be added to the suit but I need to inform the Honorable Court that I am sight/vision impaired. I also need the form for an A.D.A. attorney to assist me and any other help offered to help me proceed in this matter. Your time - (over)

Outside Facilities Con't

P.2

Facility UMMC Midtown Campus Friedenwald
Eye Institute

City Baltimore

State Maryland

Service 2019

Initiated 2019

Care End I go every 6 months to monitor
my eyes now.

Facility Meritus Medical Center

City Hagerstown

State Maryland

Service 2-12-25

Initiated ~~2-12-25~~ started 2-12-25 admitted

Care End Discharged 2-19-25 but care still going
on

Medical Injuries Continued

- much blood I had to get "3" blood transfusions, they did a colonoscopy to see where the blood was coming from, my lungs collapsed and I had pneumonia! I was in intensive care for a few days and a regular room til my lungs cleared but I am still suffering. I get really bad acid reflux and I got an inhaler for shortness of breath.

(over)

Injuries(Con't)

P.3

As far as glaucoma, I had trauma to my eyes from incarceration. I was only given medication but the chronic hypertension has been related to the glaucoma. Both of these injuries exacerbated as well over the years.

Renard McClain
Renard McClain
217-269sid 1300894

and assistance in this matter
are well appreciated.

Yours Truly,
Renard McClain
Renard McClain

Tehum Personal Injury Settlement Trust

Administered by NextClaim Solutions

PO Box 89 Wilmington DE, 19899

(866) 372-2884

support@tehumcareservicesettlement.com

October 2, 2025

Renard McClain
#217-269/1300894 Roxbury Correctional Institution
18701 Roxbury Rd
Hagerstown, MD 21746-1002

RE: Disallowance Notice: Token# R7CGD2TV– Renard McClain

Dear Renard McClain,

The Tehum Personal Injury Settlement Trust ("Trust") has evaluated your Trust Claim and has determined that it is not compensable under the Tehum Care Services, Inc. Trust Distribution Procedures for Personal Injury Settlement Claims ("TDP"). The Trust has disallowed the claim.

Your Trust Claim fails to meet the following designated threshold eligibility criteria ("Threshold Criteria") requirement(s) outlined in Article IV(D) of the TDP:

- ☒ (1) have timely filed, or have been deemed to have timely filed, a Proof of Claim with the Bankruptcy Court;
- ☐ (2) have personally signed his or her Proof of Claim attesting to the truth of its contents under penalty of perjury, or supplements his or her Proof of Claim to so provide such verification;
- ☐ (3) have filed a Proof of Claim that is free of material defect such that the Trustee is able to determine from the Proof of Claim that Trust Claim is *prima facie* valid and is not barred by any applicable federal or state statute of limitations or repose; and
- ☐ (4) have not previously had his or her Trust Claim dismissed on the merits or have received payments on his or her Trust Claim so that no recovery from the Trust would be permissible under the TDP, including ARTICLE X.

Since you did not satisfy the Threshold Criteria, the Trustee has deemed your claim to be a Disallowed Claim that shall not be paid by the Trust.

Thank you,

Tehum Personal Injury Settlement Trust Claims
Administrator

TEHUM CARE SERVICES, INC. PERSONAL INJURY TRUST

Trust Claim Submission Form

This Trust Claim Submission Form must be submitted and received by August 8, 2025. Carefully read the following instructions included with this Trust Claim Submission Form and complete all applicable questions to the extent of your knowledge or recollection. If this Trust Claim Submission Form is being completed in hard copy, please write or type clearly using blue or black ink.

The Trust Claim Submission Form must be delivered to NextClaim Solutions, the "Claims Administrator" for the Tehum Personal Injury Settlement Trust Agreement (the "Trust") by August 8, 2025 at 11:59 p.m. (ET). The Trust Claim Submission Form can be submitted by either:

- a) First class mail or courier to:

**Tehum Care Services Settlement
PO Box 89
Wilmington DE 19899**

Note: This is the exclusive address for correspondence. Do not send mail directly to the Trustee.

- b) Electronically, using the claim submission portal at:

www.tehumcareservicessettlement.com

Trust Claim Submission Forms sent by email or facsimile transmission will not be accepted.

Claimants may not be able to access supporting documentation uploaded to their Trust Claim Submission Form following claim submission. Claimants should maintain copies of supporting documentation for their records.

Capitalized terms not otherwise defined herein shall have the same meaning as provided in the Joint Chapter 11 Plan of the Tort Claimants' Committee, Official Committee of Unsecured Creditors, and Debtor filed as Dkt. # 1739, in Case No. 23-90086 in the United States Bankruptcy Court for the Southern District of Texas Houston Division.

A complete list of terms can be found on the Tehum Care Services Settlement Trust website here:
www.tehumcareservicessettlement.com

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152, 157 and 3571.

CONFIDENTIALITY

Documents submitted to the Trust by a PI/WD Claimant ("Trust Claim Submission") are for the sole benefit of the Trust and not third parties or defendants. Trust Claim Submissions and any documents submitted to the Trust, shall be treated as made during settlement discussions between the PI/WD Claimant and the Trust and are intended by the parties to be confidential and to be protected by all

applicable state and federal privileges, including those directly applicable to settlement discussions. The Trust will preserve the confidentiality of Trust Claim Submissions and shall disclose the contents thereof only to such persons as authorized by the PI/WD Claimant, the Order Confirming the First Modified Joint Chapter 11 Plan of Reorganization of the Tort Claimants' Committee, Official Committee of Unsecured Creditors, and Debtor, the Trust Distribution Procedures for Personal Injury Claims ("TDPs"), or in response to a valid subpoena of such materials, seeking non-privileged, non-mediation protected materials, issued by the United States Bankruptcy Court for the Southern District of Texas, or any other court of competent jurisdiction. The Trust shall on its own initiative or upon request of the PI/WD Claimant(s) take all necessary and appropriate steps to preserve all privileges. However, the Trust may disclose information, documents, or other materials reasonably necessary in the Trust's judgment to: (i) one or more consultants and professionals (including a third party claims processing firm) retained by the Trust to assist in the administration of the PI/WD Claims; and (ii) preserve, obtain, litigate, resolve, or settle insurance coverage, or pursue any other claims transferred or assigned to the Trust by a PI/WD Claimant or by operation of the Plan; provided, however, that the Trust shall take all steps reasonably feasible to preserve the further confidentiality of such information, documents, and materials.

CLAIM ELIGIBILITY

Only an Allowed Claim Amount can be paid by the Trust. To be eligible to receive compensation from the Tehum Personal Injury Settlement Trust, the following Threshold Criteria must be met:

- (1) Filed a timely Proof of Claim with the Bankruptcy Court;
- (2) Personally signed a Proof of Claim attesting to the truth of its contents under penalty of perjury, or supplements the filed Proof of Claim to provide such verification;
- (3) Filed a Proof of Claim that is complete and free of material defect and valid under applicable law; and
- (4) Have not previously had his or her Trust Claim dismissed on the merits or have received payments on his or her Trust Claim so that no recovery would be permissible under the TDP.

Note: Claimants who elected an *Expedited Distribution* are still required to submit a Trust Claim Submission Form, however they will not be required to submit proof of injury data or documentation.

CLAIMANT SUPPORT SERVICES

Additional information on completing this Trust Claim Submission Form can be found by visiting the settlement website www.tehumcareservicessettlement.com, emailing support@tehumcareservicessettlement.com, or calling (866) 372-2884 / (913) 382-2673.

The Claims Administrator and the Trustee of the Trust cannot provide legal advice.

SECTION 1: IDENTIFYING INFORMATION

A. Identity of Claimant

Claimant's Unique Token: R7CGD2TV

First Name	Renard
Middle Initial	J.
Last Name	McClain
Suffix	—
Aliases	—
Social Security Number	217-84-2651
Birthdate	8-12-71
Gender	Male

Is the PI/WD Claimant living or deceased?

☒ Currently Living☐ Deceased

If deceased, Claimant Date of Death: ___/___/___

Please include death certificate.

If the Claimant is living, submit one form of acceptable identification.

Current Contact Info

If PI/WD Claimant is deceased, please provide the address of the Personal Representative

Street Address	18701 Roxbury Road
Apartment/Suite	—
City	Hagerstown
State	Maryland
Zip Code	21746
Country	United States
Email Address*	—
Best phone number	—
Alternative phone number:	—

*Only provide an email address that is currently accessible for the Claimant or Personal Representative for deceased Claimants

If PI/WD Claimant is currently incarcerated, please provide the name of the facility:

Roxbury Correctional Institution

If the PI/WD Claimant is incarcerated, provide the Claimant's prison identification number (if known):

217-269 sid 1300894

B. Attorney

If the PI/WD Claimant is represented by counsel, please provide the following information:

Law Firm Name	
Attorney's Name	
Street Address	
Suite	
City	
State	
Zip Code	
Country	
Email Address	
Phone number	
Fax Number	

If you are not represented by an attorney, please indicate how you would like to receive correspondence (check the appropriate boxes):

☐ Email ☒ US Mail ☐ Telephone

C. Personal Representative

Would you like to designate another individual with whom we can discuss your claim? If yes, please:

- Complete Personal Representative fields below
- Submit relevant legal documentation (Power of Attorney)
- Submit one form of acceptable identification for the Personal Representative

If a Personal Representative is submitting on behalf of a **deceased** PI/WD Claimant, please:

- Complete Personal Representative fields below
- Submit Claimant's death certificate
- Submit relevant legal documentation (Certificate of Official Capacity, Letters Testamentary)
- Submit one form of acceptable identification for the Personal Representative

If Personal Representative is submitting on behalf of an **incapacitated** PI/WD Claimant, please:

- Complete Personal Representative fields below
- Submit relevant legal documentation (Power of Attorney, Living Will)
- Submit one form of acceptable identification for the Personal Representative

Personal Representative Information

First Name	
Middle Initial	
Last Name	
Suffix	

Aliases	
Social Security Number	
Birthdate	
Street Address	
Apartment / Suite	
City	
State	
Zip Code	
Country	
Email Address*	
Best phone number	
Alternative phone number:	

*Only provide an email address that is currently accessible for the Claimant's Personal Representative

SECTION 2: CLAIM PROCESS ELECTION

PI/WD Claim Process Options

- A. Expedited Distribution.** A PI/WD Claimant with an Allowed Claim may elect to receive an Expedited Distribution of \$5,000. A PI/WD Claimant who elects to receive the Expedited Distribution shall have no other remedies with respect to his or her Allowed Claim against the Trust and will not be eligible to receive any further distributions from the Trust. The Expedited Distribution amount may be reduced if the PI/WD Claimant with an Allowed Claim has outstanding governmental lien liability.
- B. Trust Claim Submissions.** To properly make a Trust Claim Submission, each submitting PI/WD Claimant, in addition to satisfying the Threshold Criteria for eligibility above, completing and filing the Trust Claim Submission, must also provide:
- **Medical Records:** Medical records or other medical evidence that contain information sufficient to support a diagnosis or treatment of any alleged injury for which the PI/WD Claimant seeks compensation.
 - **Description of Injury:** A written narrative or an audio or video recording detailing the PI/WD Claimant's injury or treatment, including a timeline of such injury or treatment. This may be provided by an attorney, personal representative, or family member of the PI/WD Claimant.
 - **Location and Date of Incarceration:** Evidence sufficient to show that the PI/WD Claimant was incarcerated at one or more facilities which the Debtor (or its predecessor) operated and provided medical services and the approximate starting and ending dates, where applicable, of incarceration at each facility.
 - **Wrongful Death:** To the extent that the submission involves a PI/WD Claimant who is deceased, the decedent's death certificate or a medical record providing proof of death.

You selected your claim process option when submitting your ballot. If you did not submit a ballot, your claim will be processed as a Trust Claim Submission.

Important: The election by a PI/WD Claimant to receive an Expedited Distribution on his or her Claim Ballot is controlling, and that such election cannot be modified through the Trust Claim Submission. The Expedited Distribution amount may be reduced if the PI/WD Claimant with an Allowed Claim has outstanding governmental lien liability.

Disclaimer: All Trust Claim Submissions are subject to review. Submitting a Trust Claim Submission does not mean the PI/WD Claimant will be entitled to an Allowed Claim. Only an Allowed Claim Amount can be paid by the Trust.

SECTION 3: INJURY AND DESCRIPTION OF CARE

Please answer each of the following questions to your best ability. If you do not know or recall, please indicate as such. Please submit all supporting medical documentation when possible, including medical services provided by facilities other than *Tehum Care Services, Inc / Corizon Health Services, Inc.*

Was medical care received while incarcerated?

☒ Yes

☐ No

Please describe all personal injuries resulting from treatment:

Check Box	Injury	Specify Injury and provide relevant details
	Wrongful Death	
	Amputation <i>E.g. Loss of limb, loss of testicle</i>	
	Complete or significant loss of mobility <i>E.g. Paralysis of Arms & Legs, Quadriplegia, Untreated Bone Breaks</i>	
	Neurological and cognitive issues <i>E.g. Stroke, Parkinson's</i>	
	Cancer <i>E.g. Failure to treat or diagnose</i>	
✓	Organ Rupture / Failure <i>E.g. Colon Rupture, Renal Failure</i>	Blood vessel ruptured inside hemorrhoid
	Sexual Abuse or Assault	
✓	Infections and immunological issues <i>E.g. Failure to treat resulting in fibrosis, meningitis, other</i>	Seroma, Pneumonia and collapsed lung
	Cardiac or vascular problems <i>E.g. Heart attack, heart damage</i>	
✓	Extreme pain and suffering	

	E.g. Untreated bowel incontinence, untreated withdrawal	
✓	Pain and suffering E.g. Untreated pain, emotional distress	I got a third hernia and I'm in constant pain
✓	Digestive and abdominal issues E.g. Untreated Crohn's Disease, hernia, enlarged prostate	I had two hernia operations
✓	Sensory impairment E.g. Complete or incomplete loss of vision, hearing	I got glaucoma in both of my eyes
	Injuries and trauma E.g. Bone break, joint injuries	
✓	Other Injuries E.g. COVID-19	Had 3 blood transfusions Also Hypertension Chronic

Nature and Circumstances of Personal Injury

Please describe any severe personal injury or aggravating circumstances. Please submit any supporting documentation including medical documentation whenever possible.

Supporting documentation includes:

- All medical documentation related to injury
- Death Certificate (if applicable)
- Personal Narrative
- Family Member/2nd party Narrative
- Pre-trial statements, initial disclosure statements

Please provide the following information regarding medical services provided while incarcerated.

Attach additional pages for multiple facilities:

Facility where medical services were provided	
Name of Facility	Roxbury Correctional Institution
City	Hagerstown
State	Maryland
Dates when medical services were provided	12-15-21, 3-28-23, 7-25-23/2-12-25
Date care was initiated	8-20-13
Date care ended (if applicable)	still going through it

If medical services for the injury were received from an outside provider, please provide the following information. Attach additional pages for multiple facilities:

Facility where medical services were provided	
Name of Facility	UMMC Midtown Campus
City	Baltimore
State	Maryland
Dates when medical services were provided	12-15-21, 3-28-23, 7-25-23
Date care was initiated	12-15-21
Date care ended (if applicable)	Still going through it

Please provide a detailed description of the nature and circumstances of your injury, including injury timeline/progression, treatment, outcome, and any other relevant details. Attach additional pages if necessary.

Hernia and Hemorrhoids were diagnosed around the same time. Hernia basically had caused the other, straining and constipation. Both injuries exacerbated with only a belt for the hernia; creams and suppositories for the hemorrhoids. Had "two" hernia surgeries then a seroma grows, had surgery to repair that and now another hernia has developed as I am in constant pain. A blood vessel ruptured in the hemorrhoids, I loss so-
(Con't)

SECTION 4: IMPACT OF PERSONAL INJURY

Please describe how PI/WD Claimant was impacted resulting from the treatment described above. Please submit any supporting documentation including medical records, counselor's treatment records, employment records, educational records, financial records, etc. Attach additional pages if necessary.

☒ Physical Health

Narrative: I'm constantly in pain and I have to take alot of medication for all of my ailments and the strongest pain

medication they will give is tylenol

☒ Psychological/ Mental Health

Narrative: I have a permanent bulge in the front of my stomach that makes me self conscious, embarass and disturbed. I have to place the hemorrhoids with my hand.

☒ Inter-personal Relationships

Narrative: People look at me as if I am fat because my shirt sticks out so I try to avoid people. I have become a loner.

☒ Vocational Capacity or Success

Narrative: I cannot lift no heavy objects so my jobs may be limited if not by the hernia then the glaucoma so now I am in a catch 22 situation

SECTION 5: EXIGENT CLAIMS

PI/WD Claimants may elect to submit their claim as either an *Exigent Health Claim* or an *Exigent Hardship Claim* if they meet the criteria outlined below. An Exigent Claim will be moved to the front of the FIFO Processing Queue.

Exigent Hardship Claim

A Personal Injury Claim that is compensable hereunder, for which the Trustee, in his or her sole discretion, determines that the PI/WD Claimant needs immediate financial assistance based on the PI/WD Claimant's expenses and all sources of available income.

Exigent Health Claim

A PI/WD Claim for which the PI/WD Claimant has provided a declaration or affidavit made under penalty of perjury by a physician who has examined the PI/WD Claimant within one hundred and twenty (120) days of the declaration or affidavit in which the physician states that there is substantial medical doubt that the PI/WD Claimant will survive beyond six (6) months from the date of the declaration or affidavit.

Are you submitting an Exigent Hardship Claim?

☒ Yes ☐ No

2" order's inside I need filing fees returned

Please submit any supporting documentation, including medical records, medical bills, financial records, tax records, etc.

Are you submitting an Exigent Health Claim?

☐ Yes ☐ No

Please submit any supporting documentation, including medical records, financial records, physician's affidavit, etc.

SECTION 6: LIEN RESOLUTION

Health Insurance Questionnaire

Federal and state laws, plus nearly all health insurance contracts require that we check with your health insurers for any "liens" they might have relating to your injur(y)(ies). We are committed to resolving these liens and maximizing your settlement take-home while also protecting your future medical benefits. Please provide the requested information so that we can contact any of those health insurance companies.

Injured Person's Name (as it appears on your insurance card(s))	
Insured Person's Date of Birth	
Street Address	
Apartment / Suite	
City	
State	
Zip Code	
Country	

In this section, please list any relevant Medicare and/or Medicaid coverage since your date of injury. Attach additional pages if necessary.

Medicare	Medicare #	
Medicaid	Medicaid #	
	Medicaid Provider	
	Medicaid State	
Other Medicaid (if applicable)	Medicaid #	
	List all States where you have lived since your injury	

I hereby acknowledge that I am solely and ultimately responsible for the satisfaction and discharge of all liens. A lien is legal claim or charge assets to secure payment or a debt or obligation ("Lien"). I shall use my best efforts to resolve all known Liens.

Notwithstanding my responsibilities to resolve all known Liens, I hereby authorize the Claims Administrator to act as the Lien Resolution Administrator to resolve all Medicare Program liens, Medicaid Program liens, and Medicare Part C Program liens, as set forth in the definition of Lien Resolution Administrator above. The Lien Resolution Administrator shall use best efforts to resolve the Medicare Program liens, Medicaid Program liens, and Medicare Part C or Part D Program liens on my behalf.

In further consideration of the payment from the Trust, I do hereby release, forever discharge, hold harmless, and covenant not to sue the Claims Administrator, its members, managers, agents or employees, and the Trustee, its agents, attorneys, or employees (the "Released Parties") from all claims arising from, relating to, resulting from or in any way connected to, in whole or in part, any act, or failure to act, of the Lien Resolution Administrator. I covenant and agree that I will honor the release as set forth in the preceding sentence and, further, that I will not (i) institute a lawsuit or other action based upon, arising out of, or relating to any Claim released hereby, (ii) participate, assist, or cooperate in any such action, or (iii) encourage, assist and/or solicit any third party to institute any such action.

I hereby acknowledge and agree that to the extent my information is incorrect or incomplete to any substantial degree, after reasonable diligence by the Lien Resolution Administrator, which results in the Lien Resolution Administrator being unable to properly verify coverage or identify Liens for which the Lien Resolution Administrator is responsible, then the Lien Resolution Administrator shall have no further responsibility for such unknown/unresolved Liens.

I acknowledge that the Trust and the Released Parties are not providing any tax advice with respect to the receipt of the payment from the Trust or any component thereof, and I understand and agree that I shall be solely responsible for compliance with all tax laws with respect to all Trust payments, to the extent applicable.

Claimant or Legal Representative Printed Name:

Renard McClain

Claimant or Legal Representative Signature:

Renard McClain

Date:

6-8-25

SECTION 7: BANKRUPTCY

Prior Bankruptcy: Does Claimant have any prior bankruptcies?

☐ Yes ☒ No

(If "Yes," Claimant is required to attach a copy of records)

Additional Bankruptcies: Does Claimant have any additional bankruptcies?

☐ Yes ☒ No

Current Bankruptcy Case: Is Claimant currently a debtor in a bankruptcy case?

☐ Yes ☒ No

If yes, please provide the following information:

Name of Case:	
Court	
Date Filed	
Case No.	
Chapter	☐ Chapter 7 ☐ Chapter 11 ☐ Chapter 12 ☐ Chapter 13
Name of Trustee	

Attach additional pages if necessary.

SECTION 8: LITIGATION

Was a claim filed against *Tehum Care Services, Inc / Corizon Health Services Inc.* in the tort system before February 13, 2023?

☐ Yes ☒ No

State where initially filed _____

Court where initially filed _____

Case number _____

Complaint Filing date _____

Liquidated Judgments

- Before the Effective Date 03/31/2025, was your PI/WD Claim liquidated by judgment of a court of competent jurisdiction? ☐ Yes ☐ No
 - was the judgment reversed or vacated on appeal? ☐ Yes ☐ No
 - is the judgment secured by a bond or other collateral which allows it to be satisfied by a source other than the Trust? ☐ Yes ☐ No
 - did the PI/WD Claimant elect to be treated as an Opt-Out Insured PI/WD Claim under the Plan? ☐ Yes ☐ No
 - what was the date of the liquidated judgment? _____
 - what was the amount of the liquidated judgment? _____
 - Has any amount of the liquidated judgment been paid? ☐ Yes ☐ No

- If so, how much has been paid? _____
- Please include documentation regarding any liquidated judgments.

Was the PI/WD Claim previously dismissed?

☐ Yes

☒ No

If YES, provide dismissal date _____

If a PI/WD Claim was not filed in the tort system against *Tehum Care Services, Inc / Corizon Health Inc. Services* before the Petition Date:

Which state/jurisdiction would the PI/WD Claimant have elected to file suit against *Tehum Care Services, Inc / Corizon Health Services Inc.*? Maryland

SIGNATURE

To be valid, this Trust Claim Submission Form must be signed by the PI/WD Claimant. If the PI/WD Claimant is deceased or incapacitated, this form must be signed by the PI/WD Claimant's representative or the attorney for the PI/WD Claimant's estate. If the PI/WD Claimant is a minor, the form must be signed by the PI/WD Claimant's parent or legal guardian, or the PI/WD Claimant's attorney. (Any form signed by a representative or legal guardian must attach documentation establishing such person's authority to sign this form for the PI/WD Claimant.)

Penalty for presenting a fraudulent claim is a fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152, 157 and 3571.

Check the appropriate box:

☒ I am the PI/WD Claimant

☐ I am the PI/WD Claimant's Personal Representative

☐ I am the PI/WD Claimant's Attorney

I have examined the information in this Trust Claim Submission Form and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing statements are true and correct.

Date:

June 8, 2025

Signature:

Renard McClain

Print Name:

Renard McClain