

What does a typical demand letter look like in an automobile accident claim to an insurance company claim?

The purpose of this letter is to enable you to properly evaluate the claim of Joe Victim. Mr. Victim is fifty-one years old. He has been happily married to Sarah Victim for 10 years.

Before the accident happened, Joe Victim was employed by General Mills where he worked for the last two or three years as a truck driver and unloader. At the time of the accident Mr. Victim was making \$12.90 an hour and was working forty hours a week. His average weekly salary was \$521.53. He also had health insurance benefits as well as pension, life insurance, sick leave and vacation benefits at General Mills. As a result of the accident, he will never be able to return to truck driving which he has done most of his adult life.

Liability in this case is excellent. Mr. Victim was southbound on Liberty Road and the defendant, Mr. Fault, was northbound on Liberty Road. Mr. Fault crossed the center line and struck the victim's vehicle head-on. An accident reconstruction was done by Police Officer Eckstein, a Baltimore County police accident and reconstruction expert, which is very thorough and places fault on your client. Apparently, this conclusion is not contradicted by any of the experts you have retained to investigate liability.

As a result of the accident, the truck which Mr. Victim was driving in was totaled and sustained at least \$33,000.00 in property damages. Most of the impact to the truck was to the front. I have enclosed copies of the pictures of the damage caused to both vehicles involved in the accident. Looking at the pictures, it is hard to believe that anyone could have survived this particular collision.

With regard to medical treatment, Mr. Victim was initially flown to Shock Trauma by helicopter where he was admitted on 4/16/04. He remained at Shock Trauma until 5/10/04 when he was discharged to a rehab hospital. Examination at the scene of the accident showed his GCS score at six and he was intubated with rapid sequence intubation for airway protection. At the scene, Mr. Victim was not able to give any history due to being intubated and unconsciousness.

Upon physical examination at the hospital, his pulse was 92, his blood pressure was 97/57, his respiration rate was 14 and he was on a ventilator. Neurologically, his GCS was 3. He was sedated and paralyzed at the scene. There was a three centimeter laceration over his right temporal region. Extra ocular movements were not intact due to the patient being paralyzed. Pupils were two millimeters and non-reactive, probably secondary to the patient being paralyzed. There were abrasions over his right chest. He did have abrasions over his abdomen. Examination of his left leg showed a left lower extremity deformity with abrasions. X-rays taken upon admission showed a pelvic fracture, a left intertrochanteric fracture and a patella fracture. A cat scan of the head showed a right temporal subarachnoid bleed and hemorrhage of the right sylvian fissure with a small amount of pre-pontine subarachnoid hemorrhage, as well as blood within the septum pallidum. Additionally, there is scattered subarachnoid hemorrhage throughout the upper right cerebrum which is slightly increased compared to other studies and contusion at the right vertex, as

well as a tiny amount of scattered left subarachnoid hemorrhage at the vertex. A right sided scalp contusion is noted. A cat scan of the chest showed atelectasis on the right with mediastinal err. His neck cat scan was negative. A cat scan of the left femur showed an intertrochanteric fracture surrounded by hemorrhage and additionally there was diastasis of the symphysis pubis and sacroiliac joint bilaterally and an avulsion fracture fragment, seen off the posterior sacrum on the left side. There was also blood in the space of retzius. X-ray of the left knee showed extensive comminuted fracture through the mid aspect of the patella with distraction craniocaudally of the fragment. X-rays of the left femur show a comminuted mid shaft fracture. The distal fragment is laterally angulated and approximately one shaft diameter medially displaced and one shaft diameter posterally displaced with an adjacent comminution fragment. X-rays of the pelvis showed a gross diastasis at the symphysis pubis of approximately 3.4 centimeters. There is also an intertrochanteric left femoral fracture, as well as some diastasis of the left and right SI joint. Finally, x-rays revealed a right radiocarpal fracture dislocation anterior with ulnar styloid avulsion and distal right radial fracture. X-ray of the left hand showed marked tissue swelling with no fracture noted. Further, a right and left sacral plural effusion, as well as heart failure was noted. His heart was enlarged. His right lung also had lower lobe atelectosis. On his left lung on the lower lobe there was a medial atelectosis.

On 5/20/05 Dr. Clifford Chong along with Dr. Free and Dr. O'Leary did an open reduction and internal fixation of the left patella in order to fix the left patella fracture. During surgery there were many fragments under the knee. As part of the surgery the patella was pieced together with K-wires. Because of the large number of wires needed in order to hold the patella together, the doctor elected not to use screws to hold the knee together and instead used 18-gage wire, which was wrapped around the patella.

Also, on 5/20/05 Dr. Jason Nasser who was assisted by Dr. Free and Dr. O'Leary did an open reduction and internal fixation of the left intertrochanteric hip fracture with intramedullary device, as well as an intramedullary nailing, a left femoral shaft fracture and an open reduction and internal fixation of the pubic symphysis. The post-operative diagnosis was multiple pelvic ring disruption, left intertrochanteric hip fracture, and a left femoral shaft fracture.

On 5/23/05 a MRI was done in order to correlate with the cat scan that was done on the brain on 5/22/05. The MRI showed multiple foci of abnormal signal identified at the right vertex, along with corpus callosum in the right frontal lobe. The MRI was consistent with a combination of diffuse axonal injury and tiny contusion. Flare images demonstrate additional foci of abnormal signal along the coronal radiata bilaterally, left basal ganglia and base of the left frontal lobe. The brain stem was normal in appearance. There was also a small amount of extra axial fluid along the frontal convexities, most consistent with small hygromas. The findings were consistent with bifrontal contusions and diffuse axonal injury necessitated by hemorrhage in the bilateral corona radiata, corpus callosum and left basal ganglia. MRI of the neck showed no evidence of core contusion.

On 6/1/05 surgery was done by Dr. Walter Seder assisted by Dr. O'Leary for a right radio-carpal fracture-dislocation, anterior, with ulnar styloid avulsion. Surgery included open reduction and internal fixation, right radio-carpal fracture-dislocation, right distal radius fracture. After surgery to his right wrist the doctor placed him in a cast and subsequently placed the wrist in a

splint. The patient was also examined on 5/19/05 because of abdominal pain and a cat scan of his abdomen and pelvis was taken. In addition to pelvic fractures and other fractures there was also evidence of left scrotal hemotoma. X-rays were also ordered on 5/26/05 of his right ankle, which showed gross soft tissue swelling about the ankle, however, no discreet fracture line was identified. X-rays on 5/29/05 were taken for possible pleural effusion, as well as atelectasis. The x-rays showed a moderate right and small left pleural effusion from heart failure or fluid overload. The heart was also enlarged. On 6/2/05 the x-ray of the heart showed a resolving right pleural effusion and less heart failure was seen as opposed to prior films on 5/30/05.

He was then admitted into the intensive care unit at Shock Trauma and taken to the neurotrauma unit. While he was there he got a right subclavian central lumen. A repeat subsequent head cat scan was done which showed a very diminished collection of blood within the subarachnoid space. The patient had surgery for his pelvic fracture, patella fracture and intertrochanteric fracture on hospital day number 3.

The patient was weaned off the ventilator without any problems. He was also found to be mrsa positive in his sputum. Swallowing evaluation and cognitive evaluation were performed. On June 1, he was admitted to the traumatic brain injury rehabilitation unit after he was discharged from cognitive therapy.

During his hospital stay at University, he had a neurosurgical consultation in order to keep an eye on his right subarachnoid hemorrhage and his right subdural frontal hemorrhage. Also during his hospitalization at University he did have a work up for deep vein thrombosis. A duplex ultrasound on 5/30/05 did show an acute deep vein thrombosis in the popliteal veins for which he were given a prescription for Lovenox and Coumadin, which he took regularly until approximately 5/23/06.

Staples were removed from his left femur on 5/9/05 and he was told to continue with physical therapy and occupational therapy.

Upon discharge from the hospital he was prescribed with the following medications, Lovenox, Zantac, Atrovent nebulizers, Albuteral Nebulizer, Colace, Morphine #4 every two hours, Tylenol, Oxycodon and Dulcolax. His discharge diagnosis was a closed head injury with intracranial bleed, right temporal subarachnoid bleed, multiple orthopedic fractures, including left mid-shaft femur fracture, left introchanteric fracture – processes below the neck of the femur, right wrist fracture dislocation, and open book pelvic fracture. He was ultimately discharged from the hospital on 5/10/05 and referred to a rehabilitation hospital in Virginia.

Upon discharge from University of Maryland Shock Trauma, he then immediately transported by ambulance to Rehabilitation Hospital in Virginia. He was admitted there on 5/10/05. Upon his admission on 5/10/05, he was seen by Dr. David Short. Dr. Short gives a history of a traumatic brain injury and multiple traumas. Dr. Short mentions that Joe was in Maryland Shock Trauma and admitted with an initial GCS score of 6 and mentions that the patient was described as anemic at the scene and was incubated. The doctor mentions that a MRI of the brain reportedly revealed bi-frontal contusions, as well as diffuse axonal injury as evidenced by the bilateral hemorrhages in the coronal radiata, corpus callosum, right vertex and left basal ganglia

regions.

When examined by Dr. Short initially the patient was not oriented for place or time and he did not know he was in the hospital. Extra ocular movements were full and pupils were reactive. The patient had a left leg immobilizer and the patient had a forearm cast on his right upper extremity for his wrist. The patient was admitted to Rehab Hospital to deal with the following problems, traumatic brain injury with diffuse axonal injury, as well as bi-frontal contusions, left femoral and intertrochanteric fractures, as well as a left patella fracture. The patient after the surgery performed at Shock Trauma was to remain non-weight bearing. He had a history of popliteal DVT. While at Shock Trauma, the hospital needed to deal with proper medication. Further, the hospital had to deal with pain management. Finally, the doctor needed to deal with the confusional state, secondary to traumatic brain injury. Dr. Short felt the patient was a good candidate for the rehab program.

Mr. Victim continued at the Rehab Hospital from 5/10/05 until 6/11/05 at which time he was discharged by Dr. Short. Upon discharge, his final diagnosis continued to be traumatic brain injury with diffuse axonal injury, left femur and intertrochanteric fracture, left toe fracture, right forearm fracture, penicillin allergy and confusional state. Medications at the time of discharge included Diovan, Motrin, Nexium, Thiamine, Multi-Vitamins, Senokot, Colace, Darvocet, Coumadin. In addition patient needed to continue receiving on -going therapy three to five times a week, including physical therapy, occupational therapy, speech therapy and cognitive aspects. By the time of discharge the patient had progressed to supervision for dressing, supervision for transfers, ambulation with supervision within 150 feet with a platform rolling walker. The doctor also wanted his family physician to monitor his coumadin.

On the patient's follow-up visit of 5/27/05 at University of Maryland, he was examined by Dr. Seder and Dr. Chong at which time the stitches were removed from the distal radius and the cast was also removed and he was placed in a moveable splint and he was to start some range of motion therapy. Examination of other wounds to his leg, thigh and hip showed numerous problems.

He was next seen by the doctors on 6/17/05 on an outpatient basis at the University of Maryland. At that time he was seven weeks post fracture and surgery and he was to do resistive exercises, as well as physical and occupational therapy.

He was subsequently admitted to the outpatient rehabilitation at Sinai Hospital on 6/18/05 and he was discharged from that program on 9/17/05. The doctor in charge of his care from Sinai during that time was Dr. Melanie White. Treatment consisted of occupational therapy, speech pathology and the physical therapy. Physical therapy focused on his pelvis and leg, as well as his right wrist and arm with the aim of developing some strength. Efforts were also made in order to enable him to get back to doing some sort of driving, although this was not successful. While treating at Sinai with the speech pathologist it was noted that he had moderate cognitive linguistic deficit. During his stay at Sinai he worked on his memory, auditory processing including talking about many things at one time and trying to work independently. During occupational therapy he worked on strengthening his left hand and arm. It was felt when he was discharged from Sinai that he would need additional therapy for his hand and arm, which was to be done in Dundalk. It was further recommended that he follow up with a psychiatric counselor. It is not clear at the time

whether he was going to be able to go back to work mentally, although the doctors felt it would be eighteen months to two years after the accident before a final determination could be made on that issue.

With regard to his driving, as part of their therapy program, Sinai was able to get Mr. Victim back in a car for short distances, although they felt it was going to be up to the MVA on whether he will be able to permanently drive.

A neuropsychological evaluation was done by Dr. Julie Fish, a neuro-psychologist at Sinai Hospital in order to evaluate the extent and depth of the cognitive deficit following his traumatic brain injury. In her report she gave a history that Mr. Victim is a high school graduate, married, that he had no children and that he had last worked as a truck driver. She notes that since the injury Mr. Victim with regard to his head has noticed a number of problems, including short term memory deficits, is likely to forget where he has placed items, has trouble keeping track of appointments, quickly forgets if he has done certain tasks – like locking a door or putting his credit card back in his wallet and he is slow in his performance of tasks, such as washing dishes. He feels more scared, uptight and angry than he previously was and his auditory comprehension is decreased. He still has not returned to work and has spent most of his time sleeping, watching TV and going to the mall, exercising and doing house work.

Testing was done by Dr. Julie Fish. IQ testing showed a full scale IQ of 77 which is within the sixth percentile and is also on the borderline range of intellectual functioning for his age. WAS-III sub test scores ranged from borderline to average. Mr. Victim's estimated premorbid IQ prior to this particular accident was suggestive that he previously functioned in the low average range. Mr. Victim's WAS-III verbal comprehension score was borderline in the seventh percentile for his age. His vocabulary was borderline second percentile and he scored in the low average range, sixteenth percentile for his abstract reasoning and general fund of information. His arithmetical skills were in the low average at sixteenth percentile. On the WAS-III processing speed index, Mr. Victim scored a deficient range second percentile and his ability to rapidly identify matching visual patterns was borderline second percentile. He also scored borderline range second percentile on a time visuomotor coding task. With regard to attention, concentration and memory Mr. Victim's WAS-III and WMS-III working memory index scores were a low average sixteenth percentile. Mr. Victim's WMS-III auditory immediate index score was borderline third percentile. Finally, on the WMS-III visual immediate index Mr. Victim scored a borderline range third percentile. On the visual delayed index he scored a low average tenth percentile. As far as emotional function, Mr. Victim's score was suggestive of a moderate level of clinical depression. With regard to the Dr. Fish's recommendations, the results of the current neuropsych evaluation identified the following; he now has a borderline verbal IQ, low average performance IQ, borderline full scale IQ, borderline verbal comprehension, low average perceptual organization, deficient visuomotor processing speed, somewhat decreased novel visuomotor problem solving skills, low average attention concentration, borderline immediate auditory memory, borderline delayed auditory memory, average delayed auditory recognition, borderline visual immediate memory and low average delayed visual memory. He also appeared moderately depressed. All of these conditions were connected to the head injury sustained in this accident.

Dr. Fish reached the conclusion that many of Mr. Victim's cognitive skills appear lower

than his estimated level of premorbid functioning. For instance his verbal IQ, full scale IQ, verbal comprehension, immediate and delayed auditory memory, immediate visual memory, novel visuomotor problem solving and possibly his attention concentration all appear at least mildly declined. Given his comprehensive deficits Mr. Victim is likely to have more difficulty functioning in the home, community and work setting as compared to his prior level of functioning. If he does pursue return to work, he will need a great deal of assistance to identify job tasks that match his current capabilities. Further, he is likely to have significant problems learning and retaining the information required for a new job. Further, Mr. Victim is also quite depressed which is likely to negatively affect his test performance. It is strongly recommended that he receive psychiatric treatment to address his depression, including very poor self esteem, anger, adjustment to changes in life since this traumatic brain injury, disinhibition and alcohol use. It should be noted that many of the cognitive, emotional and behavioral issues noted above are commonly associated with traumatic brain injuries, particularly when there is damage in the frontal lobe. In the report of Dr. Melody White, dated 10/6/05, she indicated that Mr. Victim continues to have higher level cognitive deficits involving memory, concentration and retention, however, he is able to make his own financial, health and personal decisions at that time and did not need a guardian appointed.

In the meantime, Mr. Victim has continued to be followed at University of Maryland Medical System by Dr. Chong and by Dr. Seder and their assistant. The visit of 7/14/05, approximately 13 weeks after the accident showed well healed incisions with no signs of infection. His left knee had a range of motion of approximately five to one hundred degrees, although he was unable to achieve full active extension. The left hip had a range of motion to ninety degrees. His quadriceps strength was approximately 3 plus and his quadriceps diameter was markedly smaller than the other side. X-rays showed good healing of all areas. At that time it was felt that the patient was progressing well with weight bearing, as well as physical therapy, as well as gait training.

When seen on 8/12/05 at the University Maryland, his right wrist was doing well with good healing and he was told to continue with occupational therapy. Weight bearing was tolerated and he was to begin on the right upper extremity, shoulder rehabilitation for rotator cuff tendonitis in the right shoulder. X-rays taken on 8/12/05 showed minimally displaced ulnar styloid process fracture, as well as a subchondral cystic change at the head of the second metacarpal.

He was seen at University of Maryland on 9/22/05 at which time he was having some numbness associated with his injury in the lower back area from lumbar plexus issues caused by the accident. He was also seen by an urologist who referred him to a neurologist to see if his urological problem was neurological in nature.

Mr. Victim did follow up with the physical therapist as suggested by Sinai Hospital after being discharged from Sinai Hospital with MedStar Health at Regional Rehab in Dundalk. Therapy was from 10/26/05 to 11/15/05 as prescribed by Dr. Seder and included therapy to his wrist and right shoulder.

He was next seen on 12/22/05 at University of Maryland at which time he was having complaints of some stiffness around the knee and complaining that he was walking with a substantial limp. The doctor mentioned that the patient had a rather substantial head injury and that this does impact his overall status and notes that he walks with a very stiff antalgic gait. X-rays

showed fractures in the lower extremities had healed and the doctor suggested that he do additional physical therapy to try and aid his walking.

Mr. Victim was seen on 1/18/06 by Dr. Ira Hand, a urologist, for urinary incontinence, possible urethral strictural secondary to the prior pelvic fracture. He had a cystoscopy and a cystometrogran. The report of March 2006 from Dr. Ira Hand indicated that Joe's sexual dysfunction and urinary incontinence are directly related to the auto accident and that these conditions are permanent and cannot be fixed.

In Dr. Hand's report of February 23, 2006, the doctor diagnosed him as having mild borderline erectile dysfunction prior to the accident; however, he finds that it was certainly exacerbated by the accident as a result of the closed head injury, as well as the fractured pelvis. In addition, the patient's urinary incontinence is also secondary to the effects of the accident, although that has been improving significantly with time. The doctor felt that the patient's erectile dysfunction would improve with medication, including Viagra, and that he would follow him conservatively with regard to the urinary incontinence since this is improving spontaneously.

He was last seen by Dr. Chong at University on 3/24/06 at which time it was found that he had reached maximum medical improvement with regard to his orthopedic issues. Dr. Chong mentioned that he did not believe he would be able to return back to the type of work he was doing before and that he should be referred for functional capacity evaluation and possible vocational rehabilitation. Dr. Chong was unclear at this point as to whether he would need any other surgery in the future. He did also suggest that he be referred to a pain clinic for pain management.

The patient was seen for a neuropsychological evaluation on January 11, 2006 by Dr. Noon. Dr. Noon reports that Victim had given him a history of sustaining multiple fractures and a closed head injury with multiple hematomas from his car accident of April 16, 2005. He stated that he was complaining of leg pain that was greater on the left side with left toe numbness, occasional right arm pain, rapidly developing tiredness if he attempts any activities, occasional back pain, left hip area pain, sad mood daily, decreased interest and pleasure from activities, daily occasional crying spells, feelings of worthlessness, feelings of not going anywhere, sleep disturbance involving four hours nightly rest compared to the typical six, guilt feelings, indecisiveness, anger, vehicle anxieties with driving avoidance, concentration problems, forgetfulness, occasional headaches, decreased sense of smell, inability to deal with the "assholes" out there, the inability to feel comfortable behind the wheel, passenger anxiety, general irritability, readily evoked anger, a sense of shortened fuse, and an inability to perform any significant information processing tasks including completion of a document resembling an application or other questionnaire of anything greater than minimal complexity. Dr. Noon relates that the client has no specific memory of the accident. Dr. Noon's assessments were: the client had lost approximately 40 pounds since the accident, that he frequently requested that questions be repeated, that his mood was depressed and his affect was dull and generally constricted, but not flat. His spontaneous speech gives the impression of an individual with low average intelligence and obvious memory problems. He had limited psychological involvement prior to this accident. The developmental history including the fact that Mr. Victim was born and raised in Baltimore, that both parents lived to be 82 and 80 years old. He graduated from Randallstown High School in 1976, and was a "C" student, although every once in a while he would pull an "A" or a "B". He reported that he had been a truck driver for 25 years

with a CDL and he had worked for General Mills for the last two years. It was reported that during several of those 15 years of a truck driver, he had maintained two jobs. Mr. Victim complained significantly about concentration, memory and information processing problems. He explained that he gets sidetracked a lot on things. He also stated that he was happy before the accident, but he is not happy now. A review of medical information indicates that Dr. Hail, his regular doctor, has known him for several years indicating that following the accident, he had developed post-traumatic stress disorder with the feelings of uselessness. He also appeared more tense and anxious. Dr. Hail reported that Xanax has helped him a lot. Dr. Noon reviewed Dr. Fish's report, and specifically pointed out that given his comprehensive deficits, Mr. Victim would more than likely have more difficulty functioning in the home community or work setting as compared to his prior level of functioning. Dr. Noon diagnosed him as having post-traumatic anxiety, depression and neuropsychological impairment caused by the work-related automobile accident on April 16, 2005. Dr. Noon felt that the vehicular anxieties and depression required desensitization and cognitively-oriented treatment in addition to his antidepressant medication. He felt that his Zoloft could certainly be increased substantially before reaching the maximum daily dose and asked Dr. Hail to increase this. Dr. Noon hoped that Mr. Victim would reach a higher level of neuropsychological functioning with the passage of time since less than one year had elapsed since his accident. The treatment plan was to desensitize him, attempt to minimize his vehicular anxieties in order to increase his functional capacities involving a vehicle. The doctor intended to use cognitively-oriented treatment to focus him on his capabilities rather than his functional limitations. He will also attempt to improve his depression and vehicle anxieties, and follow him neuropsychologically with any additional testing necessary to establish vocational capacities and permanency ratings. The actual summary diagnostic impressions were: major depressive disorder, anxiety disorder (partly pre-existing, partly due to the accident), and cognitive disorder (caused by this particular accident).

On February 11, 2006, after several weeks of therapy, Dr. Noon wrote that Joe had become more open in psychotherapy, acknowledging his feelings of loss, frustration, anger and difficulty in accepting likely impairments resulting from his occupational injury. He has gained insight into the fact that he is different. He apparently is driving more, but only for short distances close to the house. He remains temporarily and totally disabled, and requires substantial additional treatment. They will continue to treat his depressive symptoms, along with his anger and irritability, and try to get him ready for vocational rehabilitation services. His head injury is limiting him and an accommodation will have to be made by future employers because of his neuropsychological deficits for forgetfulness, in addition to his physical problems. He often repeats himself in psychotherapy forgetting that he had made a particular comment earlier in the visit. Finally, he was seen again by Dr. Noon on March 18, 2006. Mr. Victim was still negative, angry, pessimistic and easily irritated. Dr. Noon noted that Mr. Victim's treatment is moving very slowly, consistent with the magnitude of his injury and limitations. He has made some initial signs of progress and they are working at trying to get him to accept his injuries. Mr. Victim continues to treat with Dr. Noon.

With regard to his future vocational prospects, Mr. Victim had a Commercial Drivers License and it is not believed that he will be able to keep the CDL, since he would not be able to pass the DOT physical exam. Joe really doesn't drive much, if at all at this point. Joe can drive a couple of blocks in his neighborhood, but is scared to death to drive any further than that.

Coincidentally, prior to the accident wage records indicate that in 2003 Joe made \$26,710.00 at General Mills. In 2002 he worked both at General Mills, as well as Tri-State Electric. In 2001 he worked for Tri-State only and made \$39,767.00 and in 2000 he made \$30,947.00. He had lost the Tri-State job and had taken the General Mills job as a stop gap until he was able to find a better paying job. It does not look like Joe will be able to return back to any type of gainful employment, when you consider all of his orthopedic injuries, as well as the traumatic brain injury and psychiatric issues. At the time of the accident Joe was 50 years old and expected to at least work until age 65. Therefore he has approximately 15 years of lost wages at 40 hours a week times \$12.90 an hour, times 52 weeks a year, times 15 years equals \$402,480.00 without considering inflation and raises. Joe also had health insurance benefits, pension, as well as vacation pay which is now lost. He now has health insurance that he picked up under his Cobra, however, he has to pay for that which runs approximately \$8,000.00 a year for family coverage.

Mr. Victim's present complaints include the following, he is unable to run, stoop, bend or kneel, he cannot sit for long periods without getting stiff and so he has to stand up, he has problems getting up if he falls. He must walk with the use of a cane most of the time, especially when walking long distances. He cannot tie his shoes and needs assistance with both his shoes and his socks, as well as buttons. He cannot clip his own toenails or wash his feet. He doesn't believe he can lift over ten pounds. When he wakes up in the morning he is very stiff and it takes him approximately 30 minutes to get dressed. In order to take a shower he has to use a shower chair for safety. When going to the store, he has problems with sales transactions and making change. He has problems doing his own banking and balancing his checkbook and paying his bills. Joe was a very proud person prior to the accident and always had a good credit rating and was very proud of the fact that he had always paid his bills on time. He now has difficulty shopping, walking long distances and carrying bags. He is unwilling to drive anywhere other than in the neighborhood and most likely will not drive further than three miles at any one time. His wife takes him to the doctors. He cannot lie on his left side. Prior to the accident he was able to do activities such as remodeling his bathroom, finishing his attic, and building and staining a deck. He painted the house, performed the yard work and general home maintenance. Now, as a result of the accident, he cannot do any of those activities. He has a lot of difficulty with stairs. He is having problems participating sexually with his wife. He is unable to camp, hike, ride a bike, play softball and billiards and swim. He cannot take his dog for as long of a walk as he used to do. He cannot play his guitar anymore. He used to bowl in a league and he is unable to do anymore. When his father died he was unable to fly out to California to see him and he was unable to attend his funeral.

With regard to scarring, Joe has a two-inch scar on his head, a six and a half inch scar on his pelvis, a nine and half inch scar on his hip, a two-inch scar on his leg, a seven-inch scar on his right knee, a five- inch scar below the knee and a five-inch scar on his hand.

Current medications are as follows:

Neurotin - 2 caplets, three times a day, 300 milligrams for headaches, seizures and nerve pain

Zoloft - 15 milligrams, 1 per day, antidepressant

Trazdone – 100 milligrams, 1 per day for sleeping

Zanax XR – 5 milligrams, 1 per day, sedative

Wararin – 7 milligrams, 1 time per day, blood thinner (just discontinued)

Nexium – 40 milligrams, 1 time per day for stomach due to all the other medications I am taking
Betral – 4 milligrams, 1 time per day for urinary incontinence
Percocet – 5 milligrams, 4 times per day for pain

ITEMIZATION OF MEDICALS TO DATE

| | | |
|--|------------------------|---------------------|
| <i>Sinai Hospital</i> | <i>6/16 to 6/30/05</i> | <i>\$2,772.54</i> |
| | <i>7/1 to 10/25/05</i> | <i>\$17,280.08</i> |
| <i>University of Maryland Shock Trauma</i> | <i>4/16 to 5/10/05</i> | <i>\$108,773.58</i> |
| <i>UMMS</i> | <i>5/27/05</i> | <i>\$634.04</i> |
| | <i>6/2/05</i> | <i>\$233.11</i> |
| | <i>6/17/05</i> | <i>\$142.08</i> |
| <i>UMMS Diagnostic Radiology</i> | <i>7/14/05</i> | <i>\$330.60</i> |
| | <i>12/16/05</i> | <i>\$185.65</i> |
| | <i>12/22/05</i> | <i>\$409.30</i> |
| <i>CRNA University of MD</i> | <i>4/20 to 5/1/05</i> | <i>\$17,042.00</i> |
| <i>Advanced Radiology</i> | <i>11/20/05</i> | <i>\$80.00</i> |
| | <i>11/15/05</i> | <i>\$26.00</i> |
| | <i>10/14/05</i> | <i>\$40.00</i> |
| <i>Dr. Diaa Hail</i> | <i>6/23/05</i> | <i>\$175.00</i> |
| | <i>8/2/05</i> | <i>\$125.00</i> |
| | <i>9/1/05</i> | <i>\$125.00</i> |
| | <i>10/6/05</i> | <i>\$125.00</i> |
| | <i>11/3/05</i> | <i>\$125.00</i> |
| | <i>1/6/05</i> | <i>\$125.00</i> |
| <i>Eye Institute</i> | <i>5/20/05</i> | <i>\$295.00</i> |
| <i>Transcare Harford County</i> | <i>5/10/05</i> | <i>\$1,123.00</i> |
| | <i>5/27/05</i> | <i>\$720.00</i> |
| | <i>6/2/05</i> | <i>\$2,104.00</i> |
| <i>Radiology Associates</i> | <i>5/11/05</i> | <i>\$30.00</i> |
| | <i>5/17/05</i> | <i>\$30.00</i> |
| | <i>5/18/05</i> | <i>\$37.00</i> |
| <i>Dr. Aaron Noon</i> | <i>2/2/06</i> | <i>\$120.00</i> |
| | <i>1/26/06</i> | <i>\$120.00</i> |
| | <i>1/10/06</i> | <i>\$750.00</i> |

| | | |
|--|---------------------------|------------------------------|
| <i>Rehabilitation Hospital</i> | <i>5/10/05 to 5/11/05</i> | <i>\$107,772.90</i> |
| <i>American Radiology</i> | <i>8/4/05</i> | <i>\$100.00</i> |
| <i>Television – Hospital</i> | | <i>\$232.50</i> |
| <i>Labcorp</i> | <i>6/14/05</i> | <i>\$49.00</i> |
| <i>Dr. Jeffrey Gober</i> | <i>7/31/05</i> | <i>\$165.00</i> |
| <i>Maryland Urology</i> | <i>9/16/04</i> | <i>\$170.00</i> |
| <i>Dr. Ira Hand</i> | <i>11/22/05</i> | <i>\$211.00</i> |
| | <i>1/18/06</i> | <i>\$1,015.00</i> |
| <i>Mercy Medical Center</i> | <i>1/18/06</i> | <i>\$875.81</i> |
| <i>NRH Physical Therapy At Dundak</i> | <i>10/26 to 11/26/05</i> | <i>\$821.22</i> |
| <i>Dr. Seder</i> | <i>5/27/05</i> | |
| | <i>6/17/05</i> | |
| | <i>8/12/05</i> | |
| | <i>10/21/05</i> | |
| | <i>11/11/05</i> | |
| | <i>5/11/06</i> | <i>\$2,627.00</i> |
| <i>St. Paul Place Pathology</i> | <i>1/18/06</i> | <i>\$134.00</i> |
| <i>Dr. Chong</i> | <i>4/16/05</i> | |
| | <i>5/27/05</i> | |
| | <i>6/2/05</i> | |
| | <i>7/14/05</i> | |
| | <i>8/12/05</i> | |
| | <i>9/22/05</i> | |
| | <i>10/21/05</i> | |
| | | <i>12/22/05</i> |
| | | <i>\$3,021.00, \$431.00,</i> |
| | | <i>\$117.00, \$117.00</i> |
| <i>Dr. Jason Nasser, University Of Maryland Orthopedic</i> | | <i>4/16/05</i> |
| | | <i>\$431.00</i> |
| | | <i>4/20/05</i> |

| | |
|---|-------------------------|
| | \$5,695.00, \$5,016.00, |
| | \$4,049.00 |
| <i>Baltimore County Fire Department 4/16/05</i> | <i>pending</i> |
| <i>University of Maryland Imaging</i> | \$1837.33 |
| <i>USA Rehab 6/11/05</i> | \$180.46 |
| <i>Royal Dynasty Limousine – transportation to Drs.</i> | \$9,019.05 |
| <i>First Scripts</i> | \$4,032.24 |
| <i>Medical Associates of Main Line</i> | \$834.06 |
| <i>Main Line Affiliates</i> | \$754.72 |
| <i>Shock Trauma Associates</i> | \$1,764.25 |
| <i>University of Maryland Neurology</i> | \$398.33 |
| <i>USA Rehab</i> | \$250.96 |
| <i>MC Behavioral Health</i> | \$711.56 |
| <i>Jeff Quip Inc.</i> | \$372.07 |
| <i>Greenspring Emergency</i> | \$27.68 |
| <i>Sinai Orthopedic</i> | \$74.19 |
| <i>Radiology Associates</i> | \$90.94 |
| <i>Sinai Pathology</i> | \$105.98 |
| <i>Rehabilitative Associates</i> | \$1,382.44 |
| <i>Associates In Surgery</i> | \$302.64 |
| <i>Sinai Rehab</i> | \$40.16 |

Total Medicals

\$309,307.47

Workers' Compensation Lien
Erie Insurance Company as of 4/15/05

\$271,000.00

Total medicals and liens

\$
5
8
0
,
3
0
7
.
4
7

Miscellaneous expenses related to medical treatment

| | |
|----------------------------------|----------|
| UUMS – TV rental | \$52.50 |
| University of Maryland – Parking | \$182.00 |
| Tolls | \$227.00 |
| Virginia – TV services | \$232.50 |
| Gas | \$233.46 |
| Recliner – Value City | \$355.94 |
| Walmart – prescription – 7/16/04 | \$66.65 |
| Hotel – 5/28/04 | \$86.24 |
| Virginia – miscellaneous items | \$82.10 |
| Kmart – miscellaneous items | \$76.12 |
| Other Miscellaneous receipts | \$389.02 |
| LensCrafters | \$279.95 |
| Mattress Warehouse | \$377.98 |
| Clothing | \$309.16 |
| Food | \$84.41 |

Total Miscellaneous **\$3,035.03**

VALUE OF CASE

| | |
|--|----------------------|
| Workers' Compensation Lien | \$271,000.00 |
| Medical in past | \$309,307.47 |
| Future medical costs | unknown at this time |
| Pain and Suffering – cap case | \$635,000.00 |
| Lost wages in past – 52 weeks thru 4/16/05 | \$27,119.56 |
| Lost wages in future Not taking into consideration cost of | \$402,480.00 |

| | |
|---|-----------------------|
| <i>living raises and merit raises and lost benefits</i> | |
| <i>Miscellaneous expenses</i> | \$3,095.03 |
| <i>Total value of case</i> | \$1,647,941.90 |
| <i>UM policy</i> | \$1,000,000.00 |
| <i>Underlying tortfeasor policy</i> | \$500,000.00 |
| <i>Less amount owed for 2 other claims</i> | \$33,000.00 |
| <i>Net Amount available to pay on tortfeasor policy</i> | \$467,000.00 |
| <i>Amount available under UM policy After deducting tortfeasor policy, minus 2 other claims</i> | \$533,000.00 |