IN THE CIRCUIT COURT OF COLE COUNTY
STATE OF MISSOURI
19th JUDICIAL CIRCUIT

LINDA GERKEN, *et al.,*	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 06AC-CC00123-03
	)	Division IV
STEVE CORSI, *et al.,*	)	
Defendants.	)	

Group 1 Client Name Date:

Group 1 Client Address

Group 1 Client DCN

Exhibit A

NOTICE TO ELIGIBLE MEMBERS

BACKGROUND

You have received this letter in the mail because the records of the Department of Social Services show that you received at least one monthly blind pension payment[1] from the blind pension fund at some point during the time period beginning February 1, 2001, and ending June 30, 2010, and you may be eligible to file a claim for compensation for blind pension payments that were not correctly calculated. This notice contains important information about your legal rights under a Judgment approving a Class Action Settlement Agreement. **You have a limited time to respond. If you do not respond within 90 days of the date of this letter you will not be entitled to any compensation. Please read this notice carefully.**

On February 16, 2005, Linda Gerken filed a class action lawsuit against the Department of Social Services, Family Support Division on behalf of all individuals who received a Missouri blind pension payment from January 1, 1992, to the present. The lawsuit is now referred to as *Linda Gerken, et al. vs Steve Corsi, et. al,* Cole County Circuit Court Case Number 06AC-CC00123-03. The Court certified a class and determined that the Department of Social Services incorrectly calculated the monthly blind pension payment due to blind pensioners at certain times. The Court also determined that any claim for incorrect payments that was due prior to February 16, 2001, is barred by the statute of limitations. The State appealed the Court's ruling.

On March ___, 2018, the Cole County Circuit Court entered a Judgment approving a Class Action Settlement Agreement under which the blind pensioners who received at least one blind pension payment

[1] Blind pension payments include Supplemental Security Income payments, whether SAB or AB-Conversion payments. SAB refers to Supplemental Aid to the Blind, while AB-Conversion refers to Aid to the Blind Conversion.

between February 1, 2001, and June 30, 2010, are entitled to file a claim for compensation for the amount that the Department underpaid their blind pension payment for that time period plus an agreed amount of interest on those underpayments. If you received any Blind Pension or Supplemental Aid to the Blind benefits during that time period, you are a member of the class and are eligible to file a claim for payment of the amount that you were underpaid, plus interest on the underpayment, minus 25% of the total for payment of the attorneys' fee for the lawyers who represented the class in the case (Class Counsel).

If you would like the read the Class Action Settlement Agreement and the Court's Judgment approving the Agreement, you may do so on the Department of Social Services website, along with a link to a copy of this notice and a claim form. The Department's website may be accessed at the following URL: www.dss.mo.gov

DISCLAIMER: EFFECT ON OTHER BENEFITS

If you are a member of the class and decide to file a claim for additional benefits to which you may be owed, the amount paid to you may have a negative impact on other government, private, or public assistance you may receive, including but not limited to Medicaid, Food Stamps and Supplemental Security Income. It is your choice whether or not to file a claim. The Department of Social Services is not responsible if it impacts your eligibility for other benefits and services.

YOU MUST FILE A TIMELY CLAIM TO RECEIVE COMPENSATION

In order to receive the additional benefits you may be owed you must submit a claim using the claim form attached to this notice. If we do not receive the claim form from you then you will not receive compensation. Please provide the name under which you received benefits, your current name, Departmental Client Number (DCN), Social Security Number and date of birth. Please complete the enclosed claim form and return it to the Department of Social Services no later than 90 days from date of this letter. **If we receive your claim after the 90-day period, your claim will be denied and you will not receive compensation. No extensions of time to file a claim form will be granted.**

Please follow the instructions below when submitting your claim:

- You may file your claim in one of two ways:

  1. You may mail your completed claim form to the Department of Social Services by United States Postal Service mail at the following address:

     Department of Social Services
     Family Support Division
     Attn: Blind Pension Lawsuit Claims Processing Unit
     PO Box 2320
     Jefferson City, MO 65102-2320

  Keep a copy of the form and record the date you sent it. We recommend that you send your claim form by certified mail, return receipt requested so that you have a record of when you mailed the claim form and when we received it.

  2. You also may submit your claim electronically by e-mailing a PDF copy of the completed claim form to the Department of Social Services at the following e-mail address:

     BPclaims@dss.mo.gov

Please use only one of these two ways to file a claim. Please do not use both.

- The Department of Social Services must receive your claim form within 90 days of the date of this letter. If we do not receive your claim form within that time frame your claim will be denied and you will not receive compensation.
- You must complete all of the information on the claim form. If your claim form is not complete your claim will be denied and you will not receive compensation.
- You must sign the claim form and certify, subject to the penalty of perjury, that the information you provide is true and accurate. If you do not sign your claim form, your claim will be denied and you will not receive compensation.
- If we deny your claim we will send you a letter explaining why we denied the claim and giving you information about how you can ask us to review the decision if you disagree with it.

WHO MAY FILE A CLAIM ON YOUR BEHALF

Only you or your authorized representative may file a claim on your behalf. An authorized representative is an individual, competent adult who is legally authorized to act on behalf of a Member of the Class. The following individuals can serve as an authorized representative of a Member:

- the Member's court appointed guardian;
- the Member's attorney;
- an individual appointed by the Member to handle his or her affairs through a valid Power of Attorney; or
- if the Member is deceased, the personal representative of the Member's estate, or the attorney for the estate.

If your claim is submitted by your authorized representative, the authorized representative must submit satisfactory documentation to prove that he or she is authorized to act on your behalf. Satisfactory documentation is limited to:

- a copy of letters of appointment of a Guardian or Court order;
- entry of appearance signed by the attorney on the attorney's letterhead and signed by the Member;
- a notarized power of attorney executed by the member; or
- letters of appointment as personal representative.

You will be legally bound by the information provided by your personal representative.

YOU MUST TELL US IF YOUR CONTACT INFORMATION CHANGES

The Department will communicate with you by United States mail at your last known address of record with the Blind Pension Program. It is **not** the responsibility of the Department to find you if you move or if your contact information changes. It is your responsibility to notify the Department of any change in your name, address, telephone number, e-mail address or your authorized representative. You must notify us of the change within 10 days of the change. You can tell the Department about the change in one of two ways:

1. You can mail your information to the Department of Social Services by United States mail at the following address:

Department of Social Services
Family Support Division
Attn: Blind Pension Lawsuit Claims Processing Unit
PO Box 2320
Jefferson City, MO 65102-2320

We recommend that you send your letter by certified mail, return receipt requested so that you have a record of when you mailed the claim form and when we received it.

2. You also can e-mail your changed information to the Department of Social Services at the following e-mail address:

BPclaims@dss.mo.gov

WHAT WILL HAPPEN AFTER YOU FILE A CLAIM

Here is what will happen when we receive your claim form:

- We will review your claim to decide whether it is a proper claim and whether the claim was received by the deadline. We will review and make a decision on all claims for all class members filing a claim before we proceed to the next step in the process.
- If we approve the claim we will send you a letter in about 120 days letting you know your claim has been approved. The letter will tell you the amount that you have been approved to receive and give you information about how to ask us to review the decision if you disagree with it.
- If we deny your claim we will send you a letter explaining why we denied the claim and giving you information about how you can ask us to review the decision if you disagree with it.

CLASS COUNSEL AND QUESTIONS ABOUT THIS NOTICE

When the Court certified the class the court appointed class counsel to represent the interests of the class. The lawyers for the class are:

John Greider
Deborah S. Greider, LLC
8000 Bonhomme Ave., #207
St. Louis, MO. 63105
Telephone: 314-727-8910
E-mail: dgreider@greiderlaw.com

John Ammann,
Legal Clinic, Saint Louis University School of Law
100 North Tucker, #704
St. Louis, MO. 63101
Telephone: 314-977-2778
E-mail: ammannjj@slu.edu

If you have any questions about this case, this notice and how to file a claim please contact class counsel or your own lawyer.

The Department of Social Services and the Attorney General's office cannot give you advice about the claims process. Please do not contact the Attorney General's Office, the Department of Social Services, the Family Support Division or Rehabilitation Services for the Blind to seek advice concerning the claims process.

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	)	Division IV
GARY SHERMAN, *et al*.,	)	
Defendants.	)	

CLAIM FORM FOR ELIGIBLE MEMBERS

I, _____ [name of Eligible Member] either personally or through my authorized representative, hereby submit a claim for reimbursement for the underpayment of blind pension benefit payments made to me, or made on my behalf, by the Department of Social Services between February 1, 2001, and June 30, 2010, and I hereby certify that I was eligible for and received at least one blind pension payment during that time period. I further state, subject to penalty of perjury, that the following information is true to the best of my own personal knowledge, information and belief:

****

To be completed by the Eligible Member [or for the Eligible Member by the Eligible member's authorized representative]:

1. I received blind pension payments for one or more months between February 1, 2001, and June 30, 2010.

2. My current mailing address is:

   _____
   _____
   _____

3. My current residence address (if different from my mailing address) is:

   _____
   _____
   _____

4. I would like all correspondence, information and payments mailed to me at:
   Either _____ Residence address
   Or _____ Mailing Address;

Or Other address:

_____
_____
_____

5. My current e-mail address is:_____
6. My social security number is:_____
7. My Date of Birth is:_____
8. My Department Client Number (DCN) is:_____
9. My phone number is:_____

The undersigned states that the foregoing information is made under affirmation, and its representations are true and correct to the best of my knowledge and belief, subject to penalties of making a false declaration.

Date _____ _____

Eligible Member

****

To be completed by the Eligible Member's authorized representative [if appropriate]:

1. I hereby certify that I am the authorized representative of _____ [name of member]. I certify subject to penalty of perjury that the information that I have provided in this claim form is true and accurate to the best of my own personal knowledge, information and belief.

2. I am either:
   ____ The Eligible Member's Attorney [Attach Entry of Appearance]; or
   ____ The Attorney-in-Fact of the Eligible Member by valid affidavit [Attach Affidavit]; or
   ____ The Eligible Member's court appointed guardian [Attach a certified copy of the Letters of Appointment and/or Copy of Court order of appointment]; or

____The personal representative of the estate of a deceased Eligible Member, or the attorney for the estate. [Attach a copy of the Letters of Appointment and/or copy of court order of appointment].

3. To the best of my knowledge, the Eligible Member received blind pension payments for one or more months between February 1, 2001, and June 30, 2010

4. The Eligible Member's current address and telephone number are:

   Address: _____
   _____
   _____

   Telephone Number: _____
   E-mail: _____

5. My current mailing address is:

   _____
   _____
   _____

6. My current residence address (if different from mailing address) is:

   _____
   _____
   _____

7. I would like all correspondence, information and payments mailed to me on behalf of the Eligible Member at:

   Either _____ Residence address
   Or _____ Mailing Address;
   Or Other address:

   _____
   _____
   _____

8. My current e-mail address is:_____

9. The Eligible Member's social security number is: _____

10. The Eligible Member's date of birth is:_____

11. The Eligible Member's Department Client Number (DCN) is:_____

The undersigned states that the foregoing information is made under affirmation, and its representations are true and correct to the best of my knowledge and belief, subject to penalties of making a false declaration (must complete notary form below).

Date _____ _____

Authorized Representative

****

State of _____

County/City of _____

On this _____ day of _____ in the year 20____ before me, _____, a Notary Public in and for said state, personally appeared _____, known to me to be the person who executed the within claim form, and acknowledged to me that he/she executed the same for the purposes therein stated.

Seal

_____

Notary Public