# NFLPA Response to **Questions of October 12, 2007**

# **EXHIBIT**

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# Bert Bell/Pete Rozelle NFL Player Retirement Plan

# Line of Duty Disability Benefits Physician's Report Form

Notice to Physicians: To preserve your independence and the integrity of the decision-making process, you must avoid all contacts with attorneys or other representatives of the player seeking disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan. Please notify Rose Mary Eves or Paul Scott at the Plan Office (Tel. No. (800) 638-3186) immediately if you are contacted by any of these individuals.

To Be Completed By Plan Office:

| 1. Pl          | ayer': | s Name                       |          | Date of Birth                                |          |   |
|----------------|--------|------------------------------|----------|--|----------|---|
| 2. Ac          | ldres  | S                            |          |  |          |   |
|                |        | d Seasons                    |          |  |          |   |
| 4. W           | hen d  | id you first examine the p   | layer? _ |  |          |   |
| 5. Ha          | ve yo  | ou or have any of your par   | tners ev | er treated the player? Ye                    | s        | No  |
| 6. W           | hat is | the nature of the impairm    | ent?     |  |          |   |
| 7. Im          | pairn  | nent Information (attach a   | dditiona | sheets if necessary)                         |          |   |
| Impairment To: | In     | npairment results from:      |          | oes illness or injury result<br>om football? | or<br>at | as the impairment persisted is it expected to persist for least 12 months from the ate of its occurrence? |
|                | 0 0    | Illness<br>Injury<br>Unknown | 0        | Yes<br>No<br>Cannot be determined            | 0 0 0    | Yes<br>No<br>Cannot be determined   |
|                | 0 0 0  | Illness<br>Injury<br>Unknown | 0        | Yes<br>No<br>Cannot be determined            | 0        | Yes<br>No<br>Cannot be determined   |
|                | 0 0 0  | Illness<br>Injury<br>Unknown | 0        | Yes<br>No<br>Cannot be determined            | 0 0 0    | Yes<br>No<br>Cannot be determined   |
|                | 0 0    | Illness<br>Injury<br>Unknown | 0 0 0    | Yes<br>No<br>Cannot be determined            | 0 0      | Yes<br>No<br>Cannot be determined   |
|                |        |                              |          |  |          |   |

#### 8. For Orthopedic Impairments:

Please rate the impairment percentage using the AMA's <u>Guides to the Evaluation of Permanent Impairment</u> (5<sup>th</sup> Edition) ("AMA Guides") by completing the detailed orthopedic evaluation impairment form for the impaired body parts. Copy the final impairment percentage ratings from those forms here. Record percentages as the BODY PART IMPAIRMENT ("BPI") for upper and lower extremity impairments only, and WHOLE PERSON IMPAIRMENT ("WPI") for spine impairments only. You may award up to three (3) percentage points for excess pain, in accordance with the AMA Guides. Do not use the range of motion test to evaluate spine impairments. Calculate the whole person impairment rating of the upper and lower extremity <u>without</u> regard to pain by multiplying the % BPI by .6 for the upper extremity and by .4 for the lower extremity.

| Upper Extremity   |                                      | +               | Pain                               |                   | Total                      |                                 | (BPI x .6)                 |
|---|--------------------------------------|-----------------|------------------------------------|-------------------|----------------------------|---------------------------------|----------------------------|
| Lower Extremity   |                                      |                 |                                    |                   |                            |                                 | (BPI x .4)                 |
| Commissal Spring  | % WPI                                | +               | Pain                               | _=                | Total                      |                                 |                            |
| Cervical Spine Thoracic Spine   |                                      |                 |                                    |                   |                            |                                 |                            |
| Lumbar Spine  |                                      | •               |                                    |                   |                            |                                 |                            |
| If player has impairm using the Combined combining more than DO NOT include add | Values Ch<br>two WPI<br>litional per | art be<br>ratin | eginning<br>gs, you v<br>age point | on pag<br>vill ne | ge 604 of t<br>ed to use t | the AMA Guid<br>he table more t | les. If you are than once. |
| You may award up to   | three (3)                            | perce           | entage po                          | oints fo          | or excess p                | oain.                           |                            |
| Pain Rating   |                                      | 9               | 6                                  |                   |                            |                                 |                            |
| 9. For Non-Orthoped   | ic Impairn                           | nents           | :                                  |                   |                            |                                 |                            |
| Please rate the loss of   | f use of he                          | aring           | s, speech,                         | and s             | ight:                      |                                 |                            |
| Hearing: 0-29   | %                                    | 30-5            | 4%                                 | 55                | -79%                       | 80% or gre                      | eater                      |
| Speech: 0-296   | %                                    | 30-4            | 9%                                 | 50-               | -69%                       | 70% or gre                      |                            |
| C: abt. 0.200   | 77                                   | 20 4            | $\Omega \Omega t$                  | 50                | 6001                       | 700/                            | + <b>4</b>                 |

| 10. Is the player's c major functional in   | ondition the prin                            | nary or contributory<br>tal bodily organ or p     | cause of the surgical repart of the central nervo   | emoval or ous system? |
|---|--|---|---|-----------------------|
| (A)   | Yes  | (B) No  |   |                       |
| If your answer is "the surgical remova      | Yes", please iden al or the major fu         | tify the affected boo<br>nctional impairmen       | ly part and describe the  | e nature of           |
| ANSWER if "N/A"                             | " appears in the b<br>n Office will forw     | lanks below. If you                               | examination? DO NO have not previously examination of the last examination of | xamined               |
| Yes   | No   | N/A   | _   |                       |
| 12. Additional rem                          | arks by physiciar                            | 1   |   | <del></del>           |
| Please attach the re                        | quired Medical F                             | Report and body par                               | t impairment rating for   | ms.                   |
| Physician's Name                            | (typed or printed                            | ):  |   |                       |
|   | Address                                      |   | 7   |                       |
|   | Telephone                                    |   |   |                       |
| and all records of the narrative reports. I | his Player given t also certify that         | o me, and have pers<br>my ratings and com         | I have personally reviews on ally reviewed the atoments reflect my best or against this Player.   |                       |
| Signature                                   |  | Examination                                       | on Date   |                       |
| Mail completed form<br>NFL Player Retireme  | with your narrative<br>ent Plan, 200 St. Par | e report to Rose Mary<br>Il Place, Suite 2420, Ba | Eves at the Bert Bell/Pete<br>altimore, MD 21202-2040   | : Rozelle             |

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### Bert Bell/Pete Rozelle NFL Player Retirement Plan

# Total and Permanent Disability Benefits Physician's Report Form

Notice to Physicians: To preserve your independence and the integrity of the decision-making process, you must avoid all contacts with attorneys or other representatives of the player seeking disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan. Please notify Rose Mary Eves or Paul Scott at the Plan Office (Tel. No. (800) 638-3186) immediately if you are contacted by any of these individuals.

To Be Completed By Plan Office:

|                 |        |      | Name                         |         | Date of Birth  |          |  |
|-----------------|--------|------|------------------------------|---------|--|----------|--|
|                 |        |      | Seasons                      | ·····   | Telephone  |          |  |
|                 |        |      | d you first examine the play | yer? (I | Date)  |          |  |
| 6               | . What | is t | he nature of the impairmen   | it?     |  |          |  |
| /<br>Impairment | -      |      | ent Information (attach add  | De      | l sheets if necessary)  pes illness or injury result  om football? | or<br>at | as the impairment persisted is it expected to persist for least 12 months from the te of its occurrence? |
|                 |        | □    | Illness<br>Injury<br>Unknown | 000     | Yes<br>No<br>Cannot be determined                                  | 0        | Yes<br>No<br>Cannot be determined  |
|                 |        |      | Illness<br>Injury<br>Unknown | 0 0     | Yes<br>No<br>Cannot be determined                                  | 0        | Yes<br>No<br>Cannot be determined  |
|                 |        |      | Illness<br>Injury<br>Unknown | 0 0     | Yes<br>No<br>Cannot be determined                                  | 0        | Yes<br>No<br>Cannot be determined  |
| -               |        |      | Illness<br>Injury<br>Unknown | 0 0     | Yes<br>No<br>Cannot be determined                                  | 0 0      | Yes No Cannot be determined  |
|                 |        |      |                              |         |  |          |  |

| 8. In your opinion, is the player totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit?   |
|--|
| (A) Yes (B) No   |
| If you checked (A), how long do you estimate the player will be unable to be gainfully employed at any occupation?   |
| If you checked (B), in what type of employment can he engage?  |
| 9. Additional remarks by physician   |
| Please attach the required Medical Report with this form.  |
| Physician's Name (typed or printed):   |
| Address  |
| Telephone  |
| I certify that I have personally examined this Player and have personally reviewed any and all records of this Player given to me, and have personally reviewed the attached narrative reports. I also certify that my ratings and comments reflect my best professional judgment, and that I am not biased toward or against this Player. |
| Signature Examination Date   |
| Mail completed form with your narrative report to Rose Mary Eves at the Bert Bell/Pete Rozelle NFL Player Retirement Plan, 200 St. Paul Place, Suite 2420, Baltimore, MD 21202-2040.   |

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# Bert Bell/Pete Rozelle NFL Player Retirement Plan

# Both Line of Duty and Total and Permanent Disability Benefits Physician's Report Form

Notice to Physicians: To preserve your independence and the integrity of the decision-making process, you must avoid all contacts with attorneys or other representatives of the player seeking disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan. Please notify Rose Mary Eves or Paul Scott at the Plan Office (Tel. No. (800) 638-3186) immediately if you are contacted by any of these individuals.

| То Ве  | Completed By Plan Office:           |   |  |
|--------|-------------------------------------|---|--|
| 1. Pla | yer's Name                          | Date of Birth   |  |
| 2. Ad  | dress                               | ,   |  |
| 3. Cre |                                     | Telephone   | · · · · · · · · · · · · · · · · · · ·  |
| 4. Wh  |                                     | blayer?   |  |
| 5. Ha  | ve you or have any of your pa       | rtners ever treated the player? Ye  | es No  |
| 6. Wh  | at is the nature of the impairn     | nent?   |  |
|        |                                     |   |  |
|        |                                     | 112,40  |  |
|        | pairment Information (attach a      | additional sheets if necessary)   |  |
|        |                                     | Does illness or injury result from football?  | Has the impairment persisted or is it expected to persist for at least 12 months from the date of its occurrence?  |
| 7. Imp | Impairment results from:            | Does illness or injury result   | or is it expected to persist for at least 12 months from the   |
| 7. Imp | Impairment results from:            | Does illness or injury result from football?  | or is it expected to persist for at least 12 months from the date of its occurrence?  Personal Persona |
| 7. Imp | Impairment results from:            | Does illness or injury result from football?  | or is it expected to persist for at least 12 months from the date of its occurrence?   |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes  | or is it expected to persist for at least 12 months from the date of its occurrence?  Personal Persona |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes Cannot be determined  Yes No No   | or is it expected to persist for at least 12 months from the date of its occurrence?  Personal Yes Cannot be determined  Yes No No   |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes  | or is it expected to persist for at least 12 months from the date of its occurrence?  Personal Yes  Cannot be determined  Yes  |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes No Cannot be determined  Yes Yes                     | or is it expected to persist for at least 12 months from the date of its occurrence?  Yes No Cannot be determined  Yes No Cannot be determined  Yes Another Yes Yes Yes Yes Yes Yes Yes Yes  |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes No Cannot be determined  Yes No Cannot be determined | or is it expected to persist for at least 12 months from the date of its occurrence?  Yes No Cannot be determined  Yes No Cannot be determined  Yes No No No No  |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes No Cannot be determined  Yes Yes                     | or is it expected to persist for at least 12 months from the date of its occurrence?  Yes No Cannot be determined  Yes No Cannot be determined  Yes Another Yes Yes Yes Yes Yes Yes Yes Yes  |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes No Cannot be determined  Yes No Cannot be determined | or is it expected to persist for at least 12 months from the date of its occurrence?  Yes No Cannot be determined  Yes No Cannot be determined  Yes No No No No  |
| 7. Imp | Impairment results from:    Illness | Does illness or injury result from football?  Pes No Cannot be determined  Yes No Cannot be determined  Yes No Cannot be determined | or is it expected to persist for at least 12 months from the date of its occurrence?  Personal No Cannot be determined  Personal No Cannot be determined  Personal No Cannot be determined   |

| 8. In your opinion, is prevented from or sub remuneration or profi  | ostantially   | r tota<br>v una  | lly disab<br>ble to en  | led to<br>gage i                                   | the extent the n any occupa  | nat he is subs<br>ation or emp   | tantially<br>loyment for   |
|---|---|--|---|--|--|--|--|
|   | es  |  | (B) No _  |  |  |  |  |
| If you checked (A), he employed at any occu   |   | lo yo  | u estima  | te the   | player will b  | e unable to b  | oe gainfully   |
| If you checked (B), in  | what typ  | oe of  | employn   | nent c   | an he engage   | e?   |  |
| 9. For Orthopedic Imp   | pairments   | :  |   |  |  |  |  |
| Please rate the of Permanent Impairm orthopedic evaluation impairment percentag PART IMPAIRMEN WHOLE PERSON IN award up to three (3) Guides. Do not use the whole person impain by multiplying the extremity. | nent (5 <sup>th</sup> I<br>impairme<br>e ratings<br>I ("BPI")<br>MPAIRMI<br>percentag<br>ne range cairment ra | Edition to the control of the contro | on) ("AM<br>orm for the<br>those for<br>apper and<br>("WPI")<br>ints for e<br>of the up | IA Gu he imporms h lowe for sp xcess to eva oper a | ides") by copaired body pere. Record or extremity poine impairm pain, in accordance spinal and lower ext | mpleting the parts. Copy to percentages impairments nents only. Yordance with impairments remity without the control of the co | detailed the final as the BODY only, and ou may the AMA c. Calculate out regard to |
| Upper Extremity<br>Lower Extremity  |   | +  | Pain  | =  | Total  |  | (BPI x .6)<br>(BPI x .4)   |
| Cervical Spine Thoracic Spine Lumbar Spine  | % WPI   | +  | Pain  | <b>=</b><br>-<br>-                                 | Total  |  |  |
| If player has impairmed using the Combined V combining more than DO NOT include add   | /alues Ch<br>two WPI  | art b<br>ratin   | eginning<br>Igs, you v  | on pa<br>will ne                                   | ge 604 of the  | e AMA Guio<br>e table more   | des. If you are than once.   |
| Combined WF   | 'I % Impa   | irme   | ent   |  |  |  |  |
| You may award up to   | three (3)   | perc   | entage po   | oints f  | or excess pa   | in.  |  |
| Pain Rating   | ***************************************   |  | %   |  |  |  |  |

| 3 10. For Non-Orthopedic Impairments:  |
|--|
| Please rate the loss of use of hearing, speech, and sight:   |
| Hearing:0-29%30-54%55-79%80% or greater Speech:0-29%30-49%50-69%70% or greater Sight:0-29%30-49%50-69%70% or greater   |
| 11. Is the player's condition the primary or contributory cause of the surgical removal or major functional impairment of a vital bodily organ or part of the central nervous system?  |
| Yes No   |
| If your answer is "Yes," please identify the affected body part and describe the nature of the surgical removal or the major functional impairment.  |
| 12. Has the player's impairment improved since the last examination? DO NOT answer if "N/A" appears in the blanks below. If you have not previously examined this player, the Plan Office will forward a copy of the Plan's last examination of this Player for your review.  Yes No N/A |
| 13. Additional remarks by physician  |
| Please attach the required Medical Report and body part impairment rating forms with this form.  |
| Physician's Name (typed or printed):   |
| Address  |
| Telephone  |
| I certify that I have personally examined this Player and have personally reviewed any and all records of this Player given to me, and have personally reviewed the attached narrative reports. I also certify that my ratings and comments reflect my best                              |

Mail completed form with your narrative report to Rose Mary Eves at the Bert Bell/Pete Rozelle NFL Player Retirement Plan, 200 St. Paul Place, Suite 2420, Baltimore, MD 21202-2040.

professional judgment, and that I am not biased toward or against this Player.

Signature \_\_\_\_\_ Examination Date \_\_\_\_