U.S. Department of Transportation
National Highway Traffic Safety Administration

DOT Auto Safety Hotline

Vehicle Owner's Questionnaire

TO REPORT VEHICLE SAFETY DEFECTS
1-888-DASH-2-DOT
(1-888-327-4236)
INTERNET: www.nhtsa.dot.gov/hotline

Date Received
2005 MAR -2 AM 8:43

Cd_or ___ ___
rt_ck ___ ___
od_rt ___ ___
up_tr ___ ___

Reference No.
10113274

OWNER INFORMATION (Type or Print)

Name

Street No. | Apt. No. | Daytime Telephone Number

City LA VERGNE | State TN | Zip Code

Do you authorize NHTSA to provide a copy of this report to the manufacturer of your vehicle? ☐ YES ☒ NO
In the absence of an authorization, NHTSA WILL NOT provide your name or address to the vehicle manufacturer.

Signature of Owner _____ Date 02/20/05

PRODUCT INFORMATION

Vehicle Identification No. (VIN.) (17 Digits) (Located at bottom of windshield on driver's side): 1FMYU60E72UA

Make: FORD | Model: EXPLORER SPORT | Year: 2002

Purchased Date: 2-10-02 | ☒ New ☐ Used

Dealer's Name: WORLD FORD OF STN MOUNTAIN Car | Dealer's City: Snellville | State: GA | Zip Code:

Engine Size (CID/CC/L): ___ | No. Cylinders: 6 | ☐ Turbo ☐ Diesel ☐ Gas ☐ Fuel Injection

Manufacture Date (on driver's door or pillar):

Transmission Type: ☐ Manual ☒ Automatic

Restraint System: ☒ Driverside Air Bag ☐ Motorbelt ☒ Passengerside Air Bag ☐ 5-Point Belt ☐ 3-Point Belt

Cruise Control: ☒ Yes ☐ No

Drivetrain: ☒ Front ☐ Rear ☐ 4-Wheel

Vehicle Type: ☐ Car ☒ Sport Utility ☐ Van ☐ Truck ☐ Minivan ☐ Motorcycle ☐ Other ___

Body Style: ☒ 2-Door ☐ 4-Door ☐ Stationwagon ☐ Pick Up Truck ☐ Other ___

FAILED COMPONENT(S)/PART(S) INFORMATION

Part Name(s):

Location: ☐ Left ☐ Right ☐ Front ☐ Rear

Failed Part(s): ☐ Original ☐ Replacement

Handicap Adaptive Equip: ☐ Yes ☐ No

TO BE COMPLETED WHEN REPORTING A TIRE FAILURE

Tire Brand | Tire Name

Complete Tire Size | DOT No.

No. of Failures | Date(s) of Failure(s) | Mileage at Failure(s) | Vehicle Speed at Failure(s)

Failed Part(s) Available? ☐ Yes ☐ No

NHTSA Previously Contacted? ☐ Yes ☐ No

APPLICABLE INCIDENT INFORMATION

(Please describe in detail the incident(s), Failure(s), Crash(es), and Injury(ies). Attach photos if available.)

Crash	Fire	Number of Persons Injured	Number of Fatalities	Reported to Manufacturer
☐ Yes ☐ No	☒ Yes ☐ No	-0-	-0-	☒ Yes ☐ No

Narrative Description of Incident(s), Failure(s), Crash(es), and Injury(ies).

Vehicle was parked in parking lot when fire

02/18/2005 12:24 FAX 001/005

NFIRS	FDID	State	Incident Date	Station	Incident Num	Exposure Num
	06701	GA	01/08/2005	23	05001128	0

1 - Basic

Location Type	Wildland Loc?	Census Tract
1		

Incident Address	City	State	ZIP Code
GWINNETT CROSSING APTS,DOL	DULUTH	GA	30096

Wildland Loc?	Cross St or Dir

Incident Type	FDID Res Alt	State Res Alt	Alarm DtTm	Arrival DtTm	# Alarms	District
131			01/08/2005 21:37:42	01/08/2005 21:47:51		

Mutual Aid	Inc No Res Alt	Controlled DtTm	Cleared DtTm	Special Study ID Study Value

NFIRS

FDID	State	Incident Date	Station	Incident Num	Exposure Num
06701	GA	01/08/2005	23	05001128	0

1 - Basic

Location Type	Wildland Loc?	Census Tract
1		

Incident Address	City	State	ZIP Code
GWINNETT CROSSING APTS,DUL	DULUTH	GA	30096

Wildland Loc?	Cross St or Dir

Incident Type	FDID Rec Aid	State Rec Aid	Alarm DT/Tm	Arrival DT/Tm	# Alarms	District
131			01/08/2005 21:37:42	01/08/2005 21:47:51		

Mutual Aid	Inc No Rec Aid	Controlled DT/Tm	Cleared DT/Tm	Special Study ID	Study Value
N		01/08/2005 21:51:36	01/09/2005 00:09:00		

Resource Form?	Res Cat Inc Adr?	First In Unit	Property Loss
No		ENGINE 23	

Actions Taken	Suppression App	Suppression Pers	Contents Loss
Extinguish	1	3	

Actions Taken	EMS Apparatus	EMS Personnel	Property Value

Actions Taken	Other Apparatus	Other Personnel	Contents Value
	1	1	

Fire Serv Deaths	Fire Serv Inj	Det Alerted Occ	Mixed Use

Civilian Deaths	Civilian Inj	HazMat Released	Property Use
			Vehicle parking area

# Involved Pers	Alarm Problem?	# Patients	# Treated	Disposition

2 - Fire

# Res Units	Not Residential?	On-Site Material	Storage Use

# Building Invl	No Bld Involved?	On-Site Material	Storage Use

# Acres Burned	Less Than One?	On-Site Material	Storage Use

Area of Origin	Form of Material	Confined Fire	Ignition Cause
Vehicle area,	Undetermined		Cause under investigation

Heat Source	Type of Material	Ignition Factors	Ignition Factors
Undetermined			

Human Factor(s)	Age	Sex

Equip Involved	Make	Year	Power Source	Suppress Factors

Model	Portability	Suppress Factors

Serial No	Suppress Factors

Printed By	Printed At	
F789/WILLIAMS, CHRISTINA	01/27/2005 15:22:15	Page 1 of 5

SIMPLE INTEREST VEHICLE CONTRACT AND SECURITY AGREEMENT

SECTION A:
Buyer's Name(s): [illegible]
Address:
City: LAS VEGAS County: CLARK
State: NV Zip:
Bus. Phone: Res. Phone:
Stock No. Salesman:

CREDITOR: [illegible]
Address: 1700 E [illegible] AVE
City: LAS VEGAS County: CLARK
State: NV Zip: 89104
Phone: (702) [illegible]

Date 07/25/2005

SECTION B: DISCLOSURE MADE IN COMPLIANCE WITH FEDERAL TRUTH-IN-LENDING ACT

ANNUAL PERCENTAGE RATE — The cost of your credit as a yearly rate:	8.39 %
FINANCE CHARGE — The dollar amount the credit will cost you:	$ 3192.39
Amount Financed — The amount of credit provided to you or on your behalf:	$ 13386.99
Total of Payments — The amount you will have paid after you have made all payments as scheduled:	$ 16579.48
Total Sales Price — The total cost of your purchase on credit, including your down payment of $ [illegible]:	$ 29725.48

Your payment schedule will be:

Number of Payments	Amount of Payments	When Payments Are Due
59	$ 278.72	MONTHLY BEGINNING 09/02/2005
1	$ 278.72	ONE ON: 08/02/2010
N/A	N/A	

Credit life insurance, credit disability insurance, [illegible] and debt cancellation [illegible] are not required to obtain credit, and will not be provided unless you sign and agree to pay the additional cost.

Type	Premium	Term	Signature
Credit life:	$ N/A	N/A	I want credit life insurance. X [illegible]
Joint credit life:	$ N/A	N/A	We want joint credit life insurance. X [illegible]
Credit disability:	$ N/A	N/A	I want credit disability insurance. X [illegible]
Credit life and disability:	$ N/A	N/A	I want credit life and disability insurance. X [illegible]
Joint credit life and disability:	$ N/A	N/A	We want joint credit life and disability insurance. X [illegible]
[illegible]	$ [illegible]	[illegible]	[illegible] X [illegible]

You may obtain property insurance from anyone you want that is acceptable to the Creditor above. If you get the insurance from the Creditor you will pay $ [illegible] and the term of the insurance will be N/A

Security: You are giving a security interest in the goods or property being purchased.
☐ Other (Check if applicable)

Filing Fees $ N/A Non-filing Insurance $ N/A

Late Charge: If a payment is more than 10 days late, you will be charged $5.00 or 5 percent of the payment, whichever is less.
Prepayment: If you pay off early, you will not have to pay a penalty. [illegible] scheduled date, and payable.

See your contract documents for any additional information about nonpayment, default, any required repayment in full [illegible]

SECTION D: VEHICLE RETAIL INSTALLMENT CONTRACT AND SECURITY AGREEMENT

This contract is made the 25TH (day) of JULY (month) of [illegible] (year), between you, the Buyer(s) shown above, and us, the Seller shown as Creditor above. Having been quoted a cash price and a credit price and having chosen to pay the credit price (shown as the Total Sales Price in Section B above), you agree to buy and we agree to sell, subject to all the terms of this contract, the following described vehicle, accessories and equipment (which are referred to in this contract as "Collateral"):

New or Used: USED Year and Make: 2001 [illegible]
Series: C1500 Body Style: [illegible] No. Cyl.: 4
If truck, ton capacity:
Manufacturer's Serial Number: [illegible]
Use for which purchased: ☒ Personal ☐ Business ☐ Agriculture

INCLUDING:
☐ Sun/Moon Roof ☐ Air Conditioning ☐ Automatic Transmission
☐ Power Steering ☐ Power Door Locks ☐ Power Seats
☒ Power Windows ☐ Tilt Wheel ☒ Vinyl Top
☐ Cassette ☐ Cruise Control ☐ ALARM System

SECTION C: ITEMIZATION OF AMOUNT FINANCED

1. Vehicle Selling Price	$ 12791.00	
Plus: Document [illegible]	$ 200.00	
Plus: Emission [illegible] on Fee	$ 30.00	
Plus: Other (EL [illegible] DMV)	$ 200.00	
Plus: Other ([illegible])	$ N/A	
Total Selling Price		$ 13321.00
2. Total Sales Tax		$ 1065.67
3. Amounts Paid to Public Officials		
a. Titling Fee	$ 25.00	
b. Registration [illegible]	$ N/A	
c. Other (N/A)	$ N/A	
TOTAL OFFICIAL [illegible] (Add 3a through 3c)	$ N/A	
4. Plus Other Charges		
a. Extended Service [illegible]	$ 1200.00	
b. Driveaway Package	$ N/A	
c. Other ([illegible])	$ N/A	
d. Other ([illegible])	$ 200.00	
Total OTHER CHARGES (Add 4a through 4d)		$ [illegible]
5. Total Cash Sales Price (Add 1 through 4)		$ 17986.58
		N/A

☐ Compact Disc Player

GREEN Color ______ Tires ______ Lic. No.

You, severally and jointly, promise to pay us the Total of Payments (shown in Section B above) according to the Payment Schedule (also shown in Section B above), until paid in full, together with interest after maturity at the Annual Percentage Rate disclosed above.

To secure such payment, you grant to us a purchase money security interest under the Uniform Commercial Code in the Collateral and in all accessions to and proceeds of the Collateral. Insurance in which we or our assignee are named as beneficiary or loss payee, including any proceeds of such insurance or refunds of unearned premiums, or both, are assigned as additional security for this obligation and any other obligation created in connection with this sale. We, our successors and assigns, hereby waive any other security interest or mortgage which would otherwise secure your obligations under this contract except for the security interests and assignments granted by you in this contract.

Address where Collateral will be located:

Street SAME AS ABOVE City ______

County ______ State ______

Your address after receipt of possession of Collateral:

Street SAME AS ABOVE City ______

County ______ State ______

NOTICE OF RESCISSION RIGHTS

If buyer signs here, the notice of rescission rights on the reverse side is applicable to this contract.

Buyer's Signature X ______

Co-Buyer's Signature X ______

Minus: Payoff [illegible]	$ N/A
Net Trade-in Allowance	$ 0.00
7. Down Payment (Other than Net Trade-in Allowance):	
a. Trade-in Sales [illegible]	$ N/A
b. Cash	$ 4000.00
c. Manufacturer [illegible]	$ N/A
d. Other (______)	$ N/A
Down Payment (7a through 7d)	$ 4000.00
8. TOTAL DOWN PAYMENT AND NET TRADE-IN ALLOWANCE (Add 6 and 7)	$ 4000.00
9. UNPAID BALANCE OF CASH SALES PRICE (Subtract 8 from [illegible])	$ 13[illegible]
10. Plus Optional Insurance Charges*	
a. Credit Life Insurance Premium Paid to (______) Term (N/A)	$ N/A
b. Credit Disability Insurance Premium Paid to (______) Term (N/A)	$ N/A
c. Debt Cancellation Coverage (GAP Coverage) Paid to ([illegible]) Term (60)	$ [illegible]
d. Other Insurance Paid to (N/A) Term (N/A)	$ N/A
11. Other Amounts Financed	
a. N/A Paid to (N/A)	$ N/A
b. N/A Paid to (N/A)	$ N/A
12. TOTAL AMOUNT FINANCED (Add 9, 10 and 11)	$ 13[illegible]

*Seller may retain or receive a portion of this amount.

STATE DISCLOSURE REQUIREMENTS: The inclusion of Section B and Section C above are incorporated in this agreement for purposes of state disclosure requirements.

Additional Terms and Conditions: The additional terms and conditions set forth on the reverse side hereof are part of this contract and are incorporated herein by reference.

OPTION: ______ You pay no Finance Charge if the Total Amount Financed, item No. 12, Section D, is paid in full on or before the ______ (day) of ______ (month) of ______ (year).

SELLER'S INITIALS: ______

SECTION E:

NOTICE TO BUYER

Do not sign this agreement before you read it or if it contains any blank spaces. You are entitled to a completed copy of this agreement. If you fail to perform your obligations under this agreement, the vehicle may be repossessed and you may be liable for the unpaid indebtedness evidenced by this agreement.

If you are buying a used vehicle with this contract, as indicated in the description of the vehicle above, federal regulation may require a special buyer's guide to be displayed on the window.

THE INFORMATION YOU SEE ON THE WINDOW FORM FOR THIS VEHICLE IS PART OF THIS CONTRACT. INFORMATION ON THE WINDOW FORM OVERRIDES ANY CONTRARY PROVISIONS IN THE CONTRACT OF SALE.

The text of the preceding two paragraphs is set forth below in Spanish.

Si usted está comprando un vehículo usado mediante este contrato según la descripción del vehículo arriba, la ley federal podrá exigir que la ventanilla demuestre una guía especial para el comprador.

LA INFORMACIÓN QUE USTED VE EN LA FORMA DE VENTANILLA PARA ESTE VEHÍCULO ES PARTE DE ESTE CONTRATO. LA INFORMACIÓN EN LA FORMA DE VENTANILLA DOMINA CUALESQUIER ESTIPULACIÓN CONTRARIA EN EL CONTRATO DE VENTA.

BUYER AND CO-BUYER ACKNOWLEDGE RECEIPT OF A TRUE AND COMPLETELY FILLED-IN COPY OF THIS CONTRACT AND THE ABOVE DISCLOSURE AT THE TIME OF SIGNING.

LIABILITY INSURANCE COVERAGE FOR BODILY INJURY AND PROPERTY DAMAGE CAUSED TO OTHERS IS NOT INCLUDED UNLESS OTHERWISE INDICATED IN SECTION C ABOVE.

Buyer: X ______ Date: 07/25/04 Co-Buyer: X ______ Date: ______

Creditor: [illegible] ______ Date: 07/25/04 By: X ______ Title: ______

CUSTOMER TRUTH IN LENDING COPY

TRUTH IN LENDING COPY 1. Give to BUYER prior to signing. 2. BUYER and SELLER sign this copy AFTER contract is signed.

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without discrimination to race, religion, color, national origin, age, or handicapping condition.

GENERAL DUTY NURSING: The hospital only provides general duty nursing care. Under this system, nurses are called to the bedside of the patient by a signal system. If the patient needs continuous special care, it is understood that the patient is responsible for the cost and the hospital is released from any and all liability arising from the fact that the said patient is not provided with such additional care.

CONSENT TO TREATMENT: The undersigned consents to the procedures, which may be performed during this hospitalization or on an outpatient basis including emergency treatment or services. These may include but are not limited to laboratory, radiology, medical or surgical tests, treatments or procedures, anesthesia or procedures as directed under the general and special instruction of the physician or surgeon. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me. I consent to laboratory studies in the event another person during my hospitalization is potentially exposed to an infectious disease from me including but not limited to Hepatitis and HIV. I authorize the hospital to preserve, retain or use for scientific or treating purposes and dispose of at its convenience any specimen, tissue or other matter taken from my body during treatment at the hospital. I authorize my physician(s) to take photographs relating to my medical condition as are considered necessary.

PHYSICIANS AS INDEPENDENT CONTRACTORS: I acknowledge that all physicians furnishing services including but not limited to radiologist, pathologists, anesthesiologists, emergency department physicians, consultants and assistants to the physician are independent contractors and not employees of the hospital. I understand that I may receive separate billing from each of these providers for services rendered.

RELEASE OF INFORMATION: Spring Valley Hospital Medical Center is authorized to release any information necessary, including copies of my hospital and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide to Spring Valley Hospital Medical Center information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until my consent is revoked by the patient. Spring Valley Hospital Medical Center releases patient's home telephone number to Gallup Surveyors for patient satisfaction follow up after discharge.

PERSONAL VALUABLES: Spring Valley Hospital Medical Center does not assume responsibility for lost or stolen items. Spring Valley Hospital Medical Center encourages that personal valuables be left at home or given to family or friends for safekeeping.

NON-SMOKING POLICY: In accordance with regulatory agency standards, the Spring Valley Hospital Medical Center is a non-smoking facility.

CAMERAS AND SURVEILLANCE EQUIPMENT: Patient has been advised the Spring Valley Hospital Medical Center uses cameras and other surveillance equipment to monitor patient/employee activities. As a condition of admission, patient hereby consents to being monitored and recorded by such cameras and surveillance equipment.

EMERGENCY DEPARTMENT ONLY / PPO PHYSICIAN NOTIFICATION: It is the responsibility of the patient to inform the hospital of the primary care physician. If the hospital is unable to contact or utilize the services of your physician, a non-PPO physician may be assigned to you. This could result in an increase in cost to you, the patient. My Primary Care Physician is: _____

USE OF THE EMERGENCY DEPARTMENT: I understand that my insurance carrier / 3rd party payor has the right to review my record for use of the emergency department. I understand that if the reason for my visit is determined by my insurance carrier / 3rd party payor to be a non-emergency, I will be responsible for the bill. I will be responsible for the triage bill, if after triage I decide to leave the Emergency Department without being evaluated by an ER physician.

ASSIGNMENT OF BENEFITS: I, the undersigned, authorize, whether I sign as agent or patient, direct payment to Spring Valley Hospital Medical Center of any hospital insurance benefits, sick benefits, injury benefits due to a liability of a third party, specified and otherwise payable to the patient but not to exceed the balance due of the hospital's regular charges for this period of hospitalization. This assignment also authorizes payment to applicable physician or specialist such as anesthesiologist, cardiologist, pathologist, pulmonologist, radiologist, neonatalist, etc., who perform services for and treatment within Spring Valley Hospital Medical Center. I understand that I am financially responsible to the hospital for charges not covered and paid by this authorization, or any other test or services deemed medically necessary by my insurance carrier or other third party payor.

AGREE TO GUARANTEE PAYMENT: For services heretofore performed or to be performed for patient by Spring Valley Hospital Medical Center whether one or more, below signed (severally, if more than one), whether as patient, agent, or guarantor, agrees and promises to pay the charges for the hospital care so provided patient in accordance with Spring Valley Hospital Medical Center then current regular rates and all costs incurred in collecting same, together with attorney's fees, which Spring Valley Hospital Medical Center deems necessary and reasonably required to enforce Spring Valley Hospital Medical Center rights. I authorize Spring Valley Hospital Medical Center to check with any credit bureau, and to verify my employment and insurance coverage.

HMO / PPO CLAIM REVIEW: If the patient is a member of a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), the insurance plan may not cover the physicians' or hospital's services or the benefits may be reduced if non-participating providers or hospitals are non participating providers with insurance organization. Many HMO / PPO Health-Plans review emergency visit claims retrospectively. The health plans review board will determine whether the situation was an emergency. This could occur even if the undersigned's physician directed the patient to the facility. If the insurance company denies the claim, the undersigned will be responsible for the Spring Valley Hospital Medical Center and physician charges. The Spring Valley Hospital Medical Center is not responsible for determining whether the patient has used a participating provider for their insurance plan.

FOR TEACHING INSTITUTIONS: Under supervision of the attending physician, students may participate in the care of the patient as a part of the medical edu
ver

was he/she notifies this hospital to the contrary in writing, he/she agrees to participate in

X _____ Unable to sign: ☐ Due to condition

Signature of patient / representative / legal guardian

10/26/04 _____ _____ 10/26/04

Date Witness Hospital representative Date

SPRING VALLEY HOSPITAL

Patient Identification

CONSENT TO TREATMENT AND CONDITIONS OF ADMISSION
18-82113 (07/04) White - Medical Records Canary - Patient Copy

DISCLAIMER AND ACKNOWLEDGEMENT
PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL

I acknowledge and agree that Spring Valley Hospital Medical Center is not responsible for the judgment or conduct of any physician who treats or provides a professional service to me. I understand that each physician is an independent contractor who is self-employed and is not the agent, servant or employee of the hospital.

Your hospital bill will not include interpretation fees or fees for services of Cardiologists, Anesthesiologists, Radiologists, Pathologists, Emergency Room Physicians, and consulting physicians, because they are independent practitioners and are not employed by the hospital. These physicians will bill you separately.

ACLARACIÓN Y ACEPTACIÓN
LOS MÉDICOS NO SON EMPLEADOES DEL HOSPITAL

Yo acepto y coincido en que Spring Valley Hospital Medical Center no es responsable por el juicio o el comportamiento de ningún médico que me provea con asistencia o servicio profesional. Yo entiendo que cada uno de los médicos es un contratista independiente y no es un agente o empleado del hospital.

Los estados de cuenta del hospital no incluyen los cargos de interpretacion de parte del Cardiologo, Anestesiologos, Radiologos, Patologo, y medicos de consulta como son practicantes independientes. Estos [illegible] por separado.

Signature of Patient/Representative/Legal Guardian
Firma del Paciente/Representante/Guardian Legal

10/26/04
Date/Fecha

Hospital Representative
Representante del Hospital

10/26/04
Date/Fecha

SPRING VALLEY HOSPITAL
A Member of the Valley Health System

Patient Identification

DISCLAIMER AND ACKNOWLEDGEMENT 10-27886 (5/03)
WHITE – MEDICAL RECORDS CANARY – PATIENT COPY

Diehard Service Checksheet
Tester ID = 0510

BATTERY CONDITION

Battery is bad.
Battery does not meet industry performance standards.
Replacement is required.

Warranty code: DKL42028
Stock Numbers -----
COMMENTS

Store: _____
Invoice: _____
Date: 10/20/2004
Time: 13:49:18

Thank you for shopping with us today.

Technician, First/Last Name

Customer Service Manager

Diehard Express Battery Service

Diehard Service Checksheet

VISUAL INSPECTION RESULTS

Battery cables GOOD

Battery cable ends GOOD

Battery tray GOOD

Belt is GOOD

Battery hold down GOOD

BATTERY RESULTS

Battery requires Fast-Charger analysis

DTB used to continue testing

DIAGNOSTIC RESULTS

Drain test OK
Vehicle started OK.
Charging system OK.

COMMENTS

Store: _____
Invoice: _____
Date: _____

Thank you for shopping with us today.

Technician First/Last Name

Customer Service Manager

DieHard Express Battery Service

Customer Claim Form

Customer Name: Mr. ARMANDO D TALORDA IV. Case Number: ACU0562079

Problems	Servicing Dealer(s)	Current? Yes or No	# of Repair Attempts	Repair Date(s)	Mileage on Date(s)	Days Out of Service
battery was practically dead. tested only 3 months/30% usage		yes	1	10/20/04	49345	1
airbag did not deploy as well as car #2 40-50mph impactspeed		yes	2	10/26/04 01/11/05	50143 50173	7244 8044
pollen filter is unpalpable to human breathing		yes	0	NONE	50178	8244

(Please indicate whether each problem is current)

[redacted]

Customer Claim Form

Case Number : ACU0562073
Contact Date : 01/24/05
Start Date :

Have you contacted the mfr regarding your claim.? ☒ YES ☐ NO

Customer Name Address

LAS VEGAS, NV

Day Phone :
Fax Number:
Customer Contact Info:

Evening Phone:
E-mail address : [redacted]talorda@yahoo.com

Vehicle Information

Name(s) that appear on vehicle title: ALFONSO H. TALORDA
Is Vehicle titled to a business: no
Percentage of time vehicle used for business purposes:
Transmission Type: Automatic
Number of vehicles owned or leased by the business : 0
Make: Acura Model: NSX Model Year: 2001 Current Mileage: 50173
Vehicle Identification Number: JH4NA1650LS
Servicing Dealer/City/State : DESERT.
Selling Dealer/City/State : DESERT, LAS VEGAS, NV
Insurance Carrier : GEICO Policy Number: 4940-84-02-96
Has vehicle been in an accident/had body damage? Yes __ No __X Date of accident:
Description of Damage :

Purchase/Lease Information *(complete left side if vehicle was purchased, or right side if vehicle was leased)*

Purchase Date: 09/01/04 Mileage at purchase:
Purchased As : Used
Is the vehicle in your possession? yes
Lienholder's Name: DESERT HONDA
Address: 1100 E. SAHARA AVENUE
City/St/Zip: LAS VEGAS , NV 89104
Phone: (702)369-3049
Lienholder Acct # : 15008662

Lease Date: Mileage at lease:
Leased As :
Is the vehicle in your possession?
Leasing Company's Name:
Address:
City/St/Zip:
Phone:
Leasing Company's Acct #:

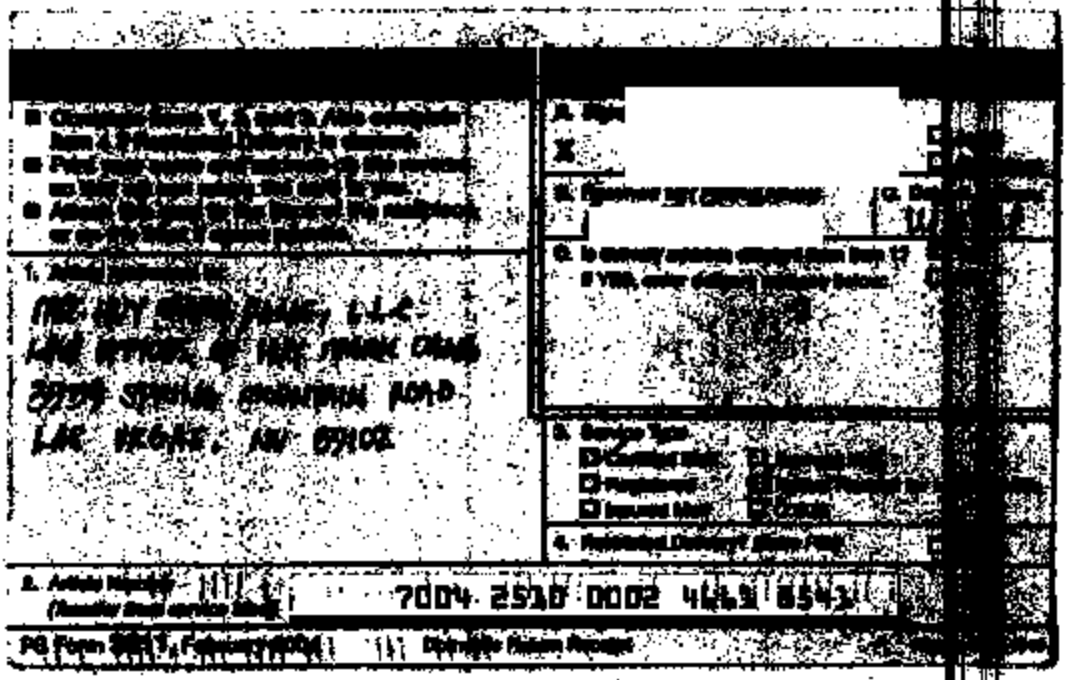
Resolution Sought

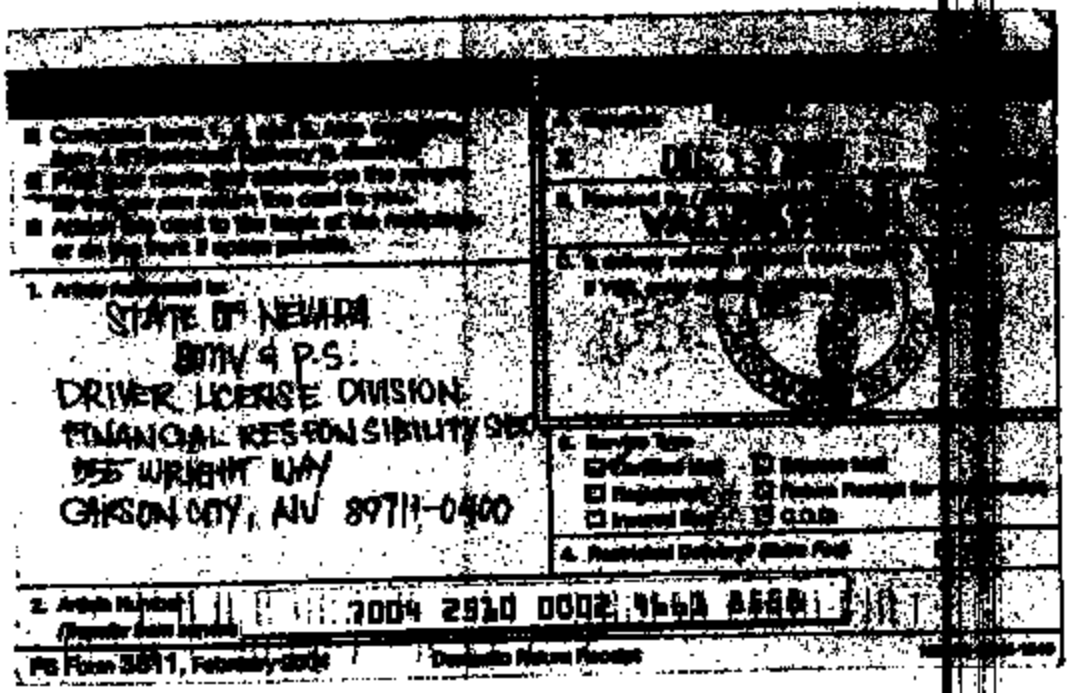
I WISH TO DO A RECALL ON ALL SAME MODELS MADE OF THE SAME YEAR TO CORRECT THE PROBLEM FREE OF CHARGE. ALSO A GENEROUS COMPENSATION OF A PAINFUL DISCOVERY WOULD BE VERY MUCH APPRECIATED AND AN APOLOGY FOR A BAD EXPERIENCE.

Signature of Owner(s): _____ Date: 31 JAN 05

I am authorizing any lienholder/lessor to disclose to the BBB AUTO LINE program all information relating to the financing or lease of the vehicle named on this Customer Claim Form.
Return the Form to: BBB AUTO LINE, 4200 Wilson Blvd., Suite 800, Arlington Va. 22203-1838

Post-it® Fax Note 7671	Date 31 JAN 05	# of pages 12
To BBB AUTOLINE COMPLIANCE	From	
Co./Dept. COF EXT 5506	Co.	
Phone # (800) 955-5100	Phone #	
Fax # (703) 247-9700	Fax #	


7004 2510 0002 4643 8543


STATE OF NEVADA
DMV & P.S.
DRIVER LICENSE DIVISION
FINANCIAL RESPONSIBILITY SEC
555 WRIGHT WAY
CARSON CITY, NV 89711-0400
7004 2510 0002

STATE OF NEVADA
DEPARTMENT OF MOTOR VEHICLES AND PUBLIC SAFETY
DRIVER LICENSE DIVISION
Financial Responsibility Section
555 Wright Way
Carson City, Nevada 89711-0400

STATE OF NEVADA DMV
DEC 13 2004
VALIDATED

SR-1 FORM

REPORT OF TRAFFIC ACCIDENT

SR-1 FORM

This form needs to be completed:

- When an accident was not investigated at the scene by law enforcement.
- ONLY if damage occurred in excess of $750 to any one person or if the accident resulted in an injury or death.
- Within 10 days of the accident.

INSTRUCTIONS:
Please complete all sections. If you do not have the information requested in any block, write "Unknown." Please sign the completed form and return it to Driver License Division at the above address. Failure to submit this form may result in the suspension of your driving privileges for up to a year.

This form cannot be accepted unless all vehicle information is completed in the spaces provided below.

LOCATION WHERE THE ACCIDENT OCCURRED: LAS VEGAS (City) CLARK (County)

Highway No. or Street Name: (SMITH'S PARKING LOT) BUFFALO STREET & FLAMINGO STREET

DRIVER INFORMATION:
If more than two vehicles were involved, please provide the additional driver and vehicle information on a separate page.

	Driver	Pedestrian	Parked Vehicle	Pedal Cyclist	Other		Driver	Pedestrian	Parked Vehicle	Pedal Cyclist	Other
No. 1	1-☑	2-☐	3-☐	4-☐	5-☐	No. 2	1-☐	2-☐	3-☐	4-☐	5-☐

Name (Last, First, Middle)

Address: LAS VEGAS NV		LAS VEGAS NV	
Driver License No. and State: NEVADA		[illegible]	Soc. Sec. no.
License Plate No.: NV 1305 SCA	Year and Make: 2001 HONDA	License Plate No.: NV [illegible] RFB	Year and Make: 1996 HONDA
Body Type: CIVIC LX 4-DR	Vehicle ID No.: JHMES16305S	Body Type: ACCORD	Vehicle ID No.: 1HGCD7629TA

OWNER INFORMATION:
If the driver and owner of the vehicle are the same, please state "Same as Above" under owner's name.

Owner's Name (Last, First, Middle): TSUKUDA, ALFONSO, MASAMUNE		Owner's Name (Last, First, Middle): [illegible] INE, RICHARD	
Owner's Address: 2744 S. FORT APACHE RD.	City: LAS VEGAS	State: NV	Zip: 89117
Owner's Address: [illegible]	City: LAS VEGAS	State: NV	Zip: 89131
Owner's Driver License No. and State	Owner's Soc. Sec. No.	Owner's Driver License No. and State	Owner's Soc. Sec. No.

ACCIDENT INFORMATION:
Date and time of accident.

Date: OCTOBER 2004 Day of Week: 26th Time: 13:25

FILL OUT OTHER SIDE COMPLETELY

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

DRIVER'S REPORT OF TRAFFIC ACCIDENT

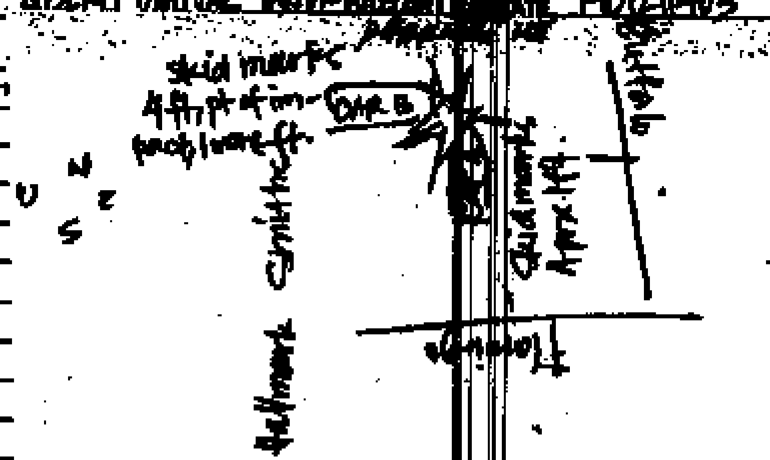
STATION REPORT - NOT INVESTIGATED AT ACCIDENT SCENE

EVENT # 041103-2650

TIME	DATE OF ACCIDENT: OCTOBER 2004 DAY OF WEEK: 26 HOUR: 13:25 AM ☐ PM ☑ TRAFFIC CLERK: op7695
PLACE	ACCIDENT OCCURRED IN CLARK COUNTY, LAS VEGAS METROPOLITAN AREA ON OR: (PARKING LOT) AT INTERSECTION WITH: BUFFALO / FLAMINGO PRIVATE ROADWAY ☐ AND PARKING LOT ☑ OTHER
ACCIDENT INVOLVED (CHECK ONE)	PEDESTRIAN ☐ BICYCLE ☐ ANOTHER MOTOR VEHICLE: MOVING ☑ PARKED ☐ OTHER ☐ ANIMAL ☐ FIXED OBJECT ☐ HIT & RUN ☐
YOUR CAR	VEHICLE (NO. 1): 2001 HONDA CIVIC LX LICENSE PLATE: 05 NV 80435 DRIVER: DATE OF BIRTH: 10 15 63 FEMALE ☐ MALE ☑ ADDRESS: LAS VEGAS, NV 89117 SSN: [illegible] OWNER: ADDRESS: 3220 S. FORT APACHE RD. LV, NV DAMAGE: FRONT OF VEHICLE PHONE NO.: (702) 341-7142 INSURANCE COMPANY: GEICO DR LICENSE/STATE: 1400222311 NEVADA
OTHER CAR	VEHICLE (NO. 2): 1996 HONDA ACCORD LICENSE PLATE: 05 NV 615 [illegible] DRIVER: DATE OF BIRTH: 12/29/2005 1914 FEMALE ☐ MALE ☑ SSN: ADDRESS: [illegible] WIMPTIENTS AVE - LAS VEGAS, NV OWNER: ADDRESS: [illegible] WIMPTIENTS AVE - LAS VEGAS NV (8913) DAMAGE: PHONE NO.: (702) 736-9611 INSURANCE COMPANY: LIBERTY MUTUAL INSURANCE DR LICENSE/STATE: 1401211403 NEVADA

OTHER PROPERTY DAMAGE

DESCRIBE WHAT HAPPENED



WITNESS TO ACCIDENT

WITNESS TO ACCIDENT: MR. PATRICK R. TELEPHONE NO. (702) 596-3140

03 NOV 04

SIGNATURE OF PERSON REPORTING THE ACCIDENT REPORT DATE

NO CRIMINAL ACTION WILL BE TAKEN

Issued To: Armando Talarda
Date: 11 3 04
Las Vegas Metropolitan Police Department
op7695

7004 2510 0002 4661 6558

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
STATE OF NEVADA
DMV & P.S.
DRIVER LICENSE DIVISION
FINANCIAL RESPONSIBILITY SEC
555 WRIGHT WAY
CARSON CITY, NV 89711-0400

A. Signature X ☐ Agent ☐ Addressee
B. Received by (Printed Name) C. Date of Delivery
D. Is delivery address different from item 1? ☐ Yes If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label): 7004 2510 0002 4661 6558

(3)

ACCIDENT INFORMATION—Continued

If you answer "Yes," please explain in the space provided.

Yes No

A. Was there damage to property other than the vehicle? (No)
Describe
Property Owner's Name
Property Owner's Address

B. Did an officer investigate at the scene of the accident? (Yes)
Officer's Name [illegible]
Agency Name [illegible]

Please write a brief description of the accident.
[illegible] 13:20, [illegible] WAS [illegible] [illegible] CAR [illegible] VEHICLE [illegible] ROAD, [illegible]

INSURANCE INFORMATION:
This information is necessary to verify that the vehicle was insured at the time of the accident. If insurance was not in effect on the date of the accident, your driving privilege and registration may be suspended under the Nevada Safety Responsibility Act.
Insurance Company Name and Address [illegible]
Policy No. [illegible]
Policy effective from [illegible] ~ [illegible]
GEICO [illegible] POLICY HOLD [illegible]
IMPORTANT: If the following section is not completed properly, this form will not be processed.

ESTIMATE OF REPAIRS:
An estimate of repairs or a statement of total loss must be completed by an established repair garage, an insurance adjuster employed by an insurance company licensed to do business in Nevada, a licensed adjuster or a properly licensed motor vehicle physical damage appraiser. If there was damage to property or a vehicle, this section must be completed.
Vehicle Year and Make 200[illegible] HONDA License No. [illegible] ID No. (VIN) [illegible]
COSTS: Parts: $ [illegible] Labor: $ 1,975.20 TOTAL COST: $ 2,[illegible]
Name of Person Making Estimate [illegible]
Employer [illegible] Official Title
Employment Address [illegible] S. DECATUR LAS VEGAS, NV [illegible]
Professional Registration Title [illegible] No. [illegible]
Signature of Person Making Estimate [signature] Date 05 [illegible]

PERSONAL INJURY:
If an injury occurred, the nature and extent of all injuries should be clearly stated. If there was an injury a doctor's statement of injury must be attached. (If more than one injury attach statement.)

Name	Age	Sex	☐ Driver ☐ Passenger	☒ In Your Vehicle ☐ In Other Vehicle ☐ Pedestrian
	41	M		

Street Address | City: LAS VEGAS, NV. | State | Relationship to Driver of Your Vehicle*

Nature and extent of injuries: NECK & BACK PAIN, MUSCLE STRAIN

*Husband, wife, son, daughter, etc.

I, ______________________ (Print or Type Name) hereby authorize the Department of Motor Vehicles and Public Safety to release my name, mailing address and insurance information to the other parties involved in the traffic accident which occurred on ______________________.

State of Nevada,
County of ______________________

______________________ Signature ______________________ Date

Signed and sworn to (or affirmed) before me on ______________ (Date) by ______________ (Name of Person)

______________________ (Signature of Notarial Officer) or ______________________ (DMV Representative)

SIGNATURE:
I hereby certify all statements made in this report are true. I agree and understand any person who completes this report knowing or having reason to believe the information is false is guilty of a gross misdemeanor. (NRS 484.[illegible])

Signature ______________________ Date 12 NOVEMBER 2004

[illegible] IF NOT SIGNED

CERTIFIED MAIL

7004 2510 0002 4661 8541

7004 2510 0002 4661 8541

■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
■ Print your name and address on the reverse so that we can return the card to you.
■ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
MR. HUY MARK DANG, L.L.C.
LAW OFFICES OF HUY MARK DANG
3799 SPRING MOUNTAIN ROAD
LAS VEGAS, NV 89102

A. Signature
X ☐ Agent ☐ Addressee
B. Received by (Printed Name) C. Date of Delivery
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.
4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7004 2510 0002 4661 8541

(2)

THE ATTACHMENTS TO THIS DOCUMENT HAVE BEEN REMOVED TO PROTECT UNWARRANTED INVASION OF PERSONAL PRIVACY PURSUANT TO EXEMPTION 6 OF THE FREEDOM OF INFORMATION ACT (FOIA), 5 U.S.C. 552(b)(6).