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

FOR AGENCY USE ONLY 100148

Date Received: 2007 SEP 20-JUL-2007 5 PM 12:30

Repository ☐

Reference No. 10197054

OWNER INFORMATION (Type or Print)

Name [redacted]

Address [redacted]

City POLIK Pollok | State TX | Zip Code [redacted]

Daytime Telephone Number [redacted]

Evening Telephone Number [redacted]

E-mail Address

Do you authorize NHTSA to provide a copy of this report to the manufacturer of your vehicle? In the absence of an [redacted] *name or address to the vehicle manufacturer.* ☒ YES ☐ NO

Signature of Owner [redacted] Date 7/31/07

VEHICLE INFORMATION

17 digit Vehicle Identification Number Located at bottom of windshield on driver's side	Make	Model	Model Year
1B7HE16Y0PS[redacted]	DODGE	D150	1993

Date Purchased	Dealer's Name and Telephone Number			Engine:	Fuel Type:
01-SEP-06	PRIVATE DEALER CAR LOT AT Home He Sells Few CARS etc.			No: Cylinders 8	Gas
Original Owner ☐	Dealer's City: LUFKIN, Texas	State: TX	Zip Code: 75969		

Transmission Type		Powertrain	Vehicle Component Code
AUTOMATIC	☐ Antilock Brakes ☒ Cruise Control	REAR WHEEL DRIVE	030000 SERVICE BRAKES, HYDRAULIC
			Multiple Failure: 1

FAILED COMPONENT(S)/PART(S) INFORMATION

Incident Date(s)	Failure Mileage	Failure Speed	
23-OCT-2006	87,006.	45	Fuel Pump - bar or accelarater malfunction Brakes couldn't stop vehicle.

ADDITIONAL ITEMS TO BE COMPLETED WHEN REPORTING A TIRE FAILURE

Tire Make

Tire Model (Name or Number)

Tire Size (Example P215/65R15)

DOT No. (Example: DOTMAL9ABC036)

☐ Original Equipment ☐ Prior Repair

Failure Location:

Tire Component Code

Tire Failure Type

ADDITIONAL ITEMS TO BE COMPLETED WHEN REPORTING A CHILD SEAT FAILURE

Make:

Seat Type:

Date Manufactured:

Model No./Name:

Child Seat Component Code:

Installation System:

Failed Part:

APPLICABLE INCIDENT INFORMATION

(Please describe in detail the incident(s), Failure(s), Crash(es), and injury(ies).)

Crash	Fire	Number of Persons Injured	Number of Deaths	Reported to Police
☒ Yes ☐ No	☐ Yes ☒ No	1 (Other)	0	Y

Narrative Description of Incident(S), Crash(es), and Injury(ies). Please describe (1) events leading up to the failure, (2) failure and its consequences, and (3) what was done to correct the failure; i.e, parts repaired or replaced (and if old part is available).

TL*THE CONTACT OWNS A 1993 DODGE D150. WHILE DRIVING 45 MPH, THE CONTACT DEPRESSED THE BRAKE PEDAL, BUT THE VEHICLE FAILED TO STOP. THE FAILURE CAUSED HIM TO REAR END ANOTHER VEHICLE. THE ROAD CONDITIONS WERE DRY. THE DRIVER SUFFERED A CONCUSSION, BODY CONTUSIONS, AND STRAINED MUSCLES. HE WAS WEARING HIS SEAT BELT AT THE TIME OF THE CRASH. A POLICE REPORT WAS FILED. BOTH VEHICLES WERE DAMAGED. THE CONTACT'S VEHICLE WAS TOWED, BUT NOT REPAIRED. NO MILEAGE INFORMATION WAS AVAILABLE.

The Truck dodge 93 skidded several feet after applying brakes real Hard, but the motor sounded like it was racing also, The Truck accelleration made it pulled against braking etc. Should have stopped before hitting other vehicle. Other person hurt - that 2 years (No anti-lock brakes.) I had no control over the acceleration.

Include, if available: Police/Fire Department Report, Photos, and Repair Invoice.

ATTACH ADDITIONAL SHEETS IF NECESSARY

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

Traveling on the loop around Tuffin, Texas I approached traffic light when it changed to Red ~~Sunday~~ suddenly. I was going 45 mph and the speed limit posted was 55 mph. I applied brakes real hard it started skidding and I put both feet on brake and it swayed some, but the motor seem to accellerate faster causing the truck to keep going - pulling against brakes. I hit vehicle ahead in rear. Had it not accellerated ~~the~~ I could've stopped. I Had no Control over acceleration.

ATTACH ADDITIONAL SHEETS IF NECESSARY

J. Wingset
6056 US-69-N
Pollok TX 75969

U.S. Department of Transportation

National Highway Traffic Safety Administration

400 Seventh St., S.W.
Washington, D.C. 20590

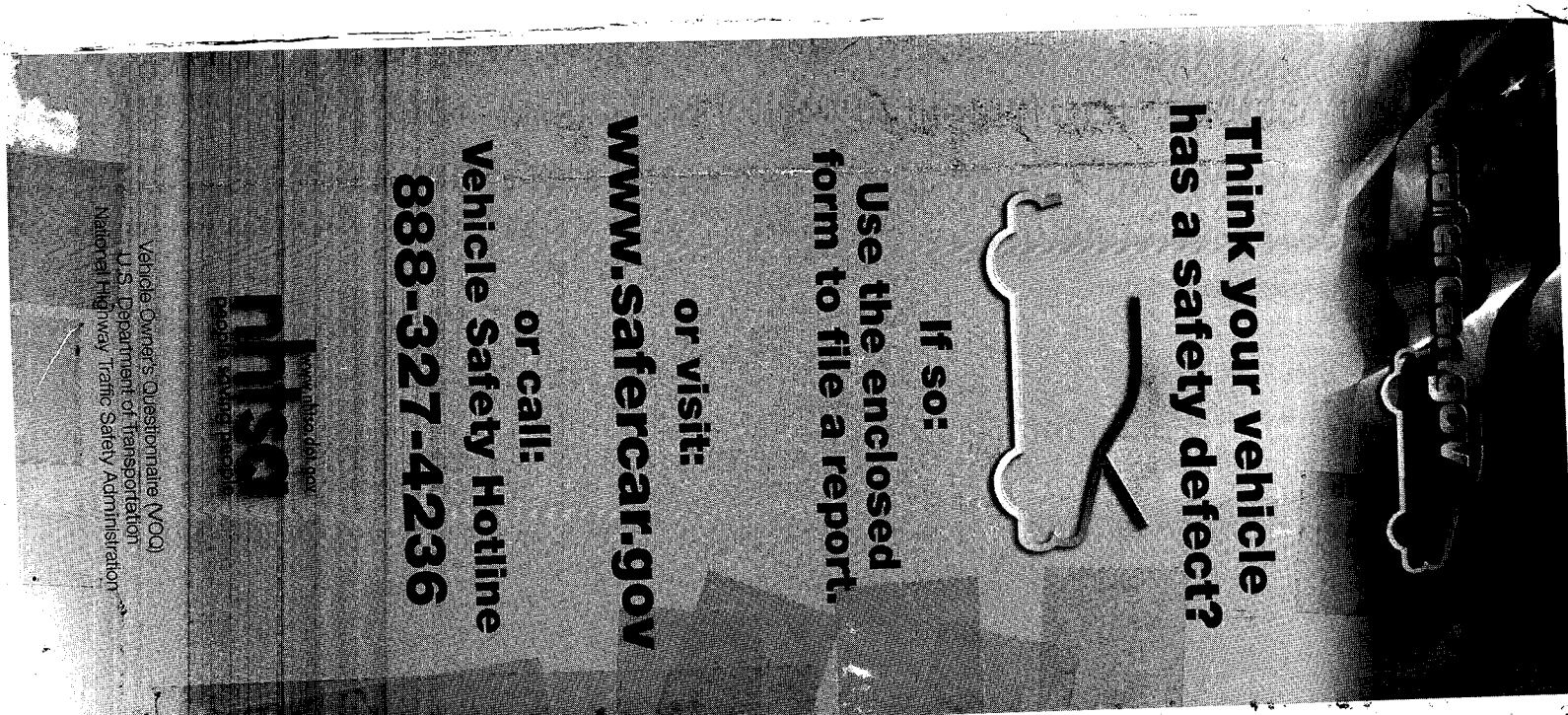
Official Business
Penalty for Private Use $300

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO 73173 WASHINGTON, D.C.

POSTAGE WILL BE PAID BY NATL. HWY. TRAFFIC SAFETY ADMIN.

U.S. Department of Transportation
National Highway Traffic Safety Administration
Office of Defects Investigation, NVS-210
400 7th Street, SW
Washington, DC 20590



SETTLEMENT AGREEMENT AND RELEASE

This agreement is entered into by and among _____ [redacted] _____ (hereinafter "Releasor"), and _____ [redacted] _____ hereinafter "Releasee"), and Southern Farm Bureau Casualty Insurance Company/Texas Farm Bureau Mutual Insurance Company/ Farm Bureau County Mutual Insurance Company of Texas/Texas Farm Bureau Underwriters (hereinafter "Company"). On or about ____Oct. 23rd_____ _____ was injured in an accident occurring at or near 20__06[redacted]___ _____ Lufkin, TX_____ (location)

Therefore, in consideration of the payments by the company of _Fifteen Thousand dollars_____ ($ _15000.00_____) the releasor hereby completely releases and forever discharges releasee and company, its agents and employees from any and all past present or future claims, demands, obligations, actions, causes of action, wrongful death claims, rights, damages, cost, losses of services, loss of consortium, expenses and compensation of any nature whatsoever, whether based on a tort, contract or other theory of recovery, which the releasor now has, or which may hereafter accrue or otherwise be acquired, on account of, or in any way growing out of the accident described above, including, without limitation, any and all known or unknown claims for bodily and personal injuries to releasor, or any future wrongful death claims of releasor's representatives or heirs, which have resulted or may result from the alleged acts or omissions of the releasee or arising out of the manner that company handled, settled or defended the releasor's claims including any bad faith, dtpa, or insurance code violations.

Releasor acknowledges that the injuries sustained may be permanent and progressive and recovery therefrom is uncertain and indefinite and there may be injuries or results of injuries not yet evident, recognized or known and in making this release,releasor relies wholly upon my/our judgement, knowledge and belief as to the nature, extent and duration of said injuries and as to the questions of liability involved and have not been influenced by any representations regarding the same; that the claims are doubtful and disputed and the above consideration is accepted in full compromise, accord and satisfaction thereof, and the payment of said consideration is not an admission of liability.

Releasor hereby agrees for myself (or ourselves) heirs, executors, administrators, successors and assigns, with the said releasee and company, their agents and employees and all other persons, firms or corporations which are or may be liable to indemnify and save them harmless on account of or in any wise growing out of said accident or its results, known and unknown, or prior claims, both to persons and property.

This release contains the entire agreement between the parties hereto, and the terms of this instrument are contractual and not a mere recital.

This contract shall be binding upon the releasor, his/her legal representatives, heirs, successors, beneficiaries, and assigns, if any. Releasor hereby declares that the terms of this settlement have been completely read and are fully understood and voluntarily accepted for the purpose of making a full, fair, and compromise settlement of any and all claims, disputed or otherwise, on account of all injuries and damages arising out of the above mentioned accident. All parties agree to execute any and all supplementary documents and to take all supplementary steps to give full force and effect to the basic terms and intent of this agreement.

This settlement agreement and release executed this day ____12th_____ of __April_____, 20_07____.

Witnesses

1. _____

2. _____

Signatures [redacted]

_____

_____

Company

By: _____Delton Carroll

Title: Claims Rep.

State of **Texas**

County of _____

On this _____ day of_____, 20____, before me personally appeared _____ to me known to be the person(s) who executed the same as his/her free act and deed.

Notary public _____

My commission expires _____

Recalls

1993 Dodge Ram D150

Select Different Vehicle

1 Recall Notice

These recall notices may not apply to all vehicles. Please contact your dealer for more details or contact the National Highway Traffic Safety Administration's Auto Safety hotline at 1-888-DASH-2-DOT (1-888-327-4236).

Campaign Number: 93E034001 **Date:** 1993-Dec-07

Component: Fuel System, Gasoline: Delivery: Fuel Pump

Defect Summary: BOSCH DISTRIBUTOR-TYPE FUEL PUMPS HAVE A MANUFACTURING DEFECT THAT CAN CAUSE THE BALL PIN, WHICH IS PART OF THE PUMP'S CONTROL LEVER ASSEMBLY, TO BREAK CAUSING THE LINK BETWEEN THE CONTROL SLEEVE AND THE CONTROL LEVER TO BECOME INOPERATIVE.

Consequence Summary: WHEN THE LINK BETWEEN THE CONTROL LEVER AND THE CONTROLSLEEVE BREAKS, THE SPEED CONTROL NO LONGER RESPONDS TO MOVEMENT OF THEACCELERATOR PEDAL, RESULTING IN LOSS OF SPEED CONTROL AND A POSSIBLE ACCIDENT.

Corrective Summary: THE FUEL PUMPS WILL BE INSPECTED, AND IF NECESSARY, REPAIRED OR REPLACED.

My P.U. is a 1993 Dodge D150
~~200~~ 87,006 Miles

TO Repair it would Cost:

Parts 2672.80
Labor 1500.00
$4172.80

Dennis Cook's Repair Shop
69 N.
936-634-9269

PLEASE DO NOT STAPLE IN THIS AREA

T062884014853

[redacted]

POLLOK, TX [redacted]

CARRIER

01 PMVA 02 TXMA

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) X

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME

[redacted]

6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY POLLOK

STATE TX

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

CITY

STATE

ZIP CODE [redacted]

TELEPHONE (Include Area Code) [redacted]

ZIP CODE

TELEPHONE (INCLUDING AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY M SEX F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

[redacted]

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME TX MEDICAID & HLTH PARTNE

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 10/24/06

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 10 23 06 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 847.0
2. 847.2
3. 920.
4. E812.0

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 24 06	10 24 06	23		99283		1,2,3,4	267.00	1		Y		
2												
3												
4												
5												
6												

Dr. Iversen Bell Pd

25. FEDERAL TAX I.D. NUMBER 04-3715256 SSN EIN

26. PATIENT'S ACCOUNT NO. 000239766543HCW

27. ACCEPT ASSIGNMENT? (For govt. claims see back) X YES NO

28. TOTAL CHARGE $ 267.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 267.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

MICHAEL IVERSEN, MD

SIGNED 01/05/07 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

WOODLAND HEIGHTS MEDICAL CENTE
505 S. JOHN REDDITT DRIVE
LUFKIN TX 75904-3157

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

REDDITT EMERGENCY PHYSICIANS
PO BOX 13100
PHILADELPHIA PA 19101-3100
800-355-2470

PIN # GRP #

CARRIER PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215 FORM OWCP-1500, APPROVED OMB-0720-001 (CHAMPUS)

CLAIM #..: 635501 ELN NOTEPAD DISPLAY 11/09/2006 08:11:28
CATEGORY: CHK TYPE: CHK AUTHOR: AX19 DEST: _____ PAGE: 1
ADJUSTER # _____

3-28-07
Pd
Hosp.
Forwrd.

CHK# 004947 $53.77 ISSUED ON 11/09/2006

PAYEE: [redacted]
[redacted]
POLLOK, TX [redacted]

PAYMENT FOR: MED BILL PRESC.
ADJ# 8273 OLD ADJ# 055 OPID: DRC TERM-ID: GD8D

ACCT#	AMOUNT	K/L	CLM/CNT	BUDGET CODE
[redacted]	$53.77	PIPM	01	

53.77
11-16

PF1:HELP PF3:RETURN PF7:BWD PF8:FWD

CLAIM #..: 635501 ELN NOTEPAD DISPLAY 11/09/2006 08:11:22
CATEGORY: CHK TYPE: CHK AUTHOR: AX19 DEST: _____ PAGE: 1
ADJUSTER # _____

CHK# 004944 $2,155.39 ISSUED ON 11/09/2006

PAYEE: [redacted]
[redacted]
POLLOK, TX [redacted]

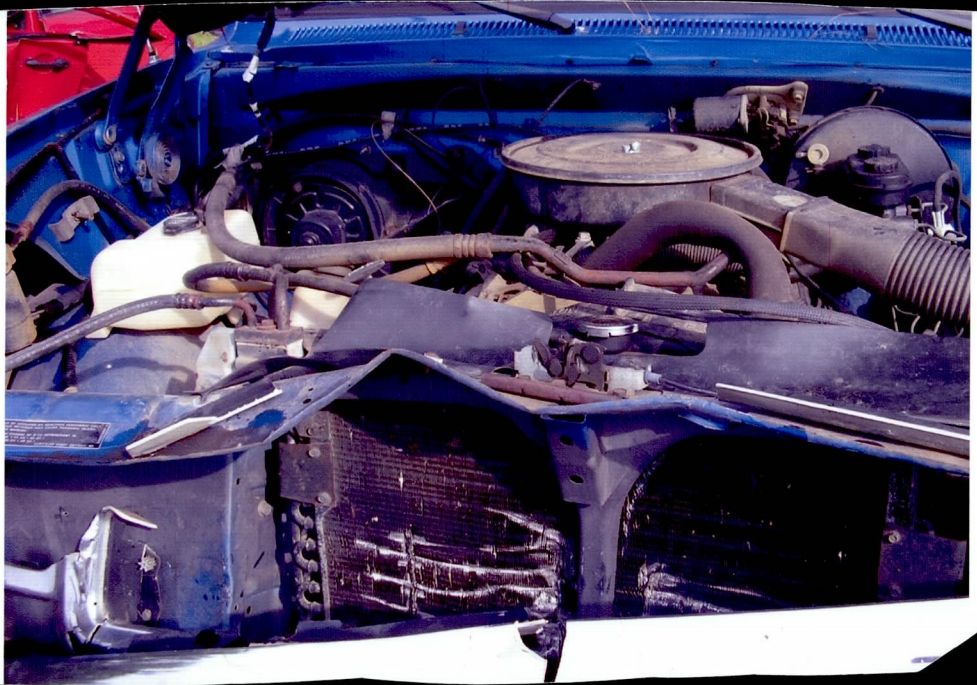
PAYMENT FOR: MED BILLS
ADJ# 8273 OLD ADJ# 055 OPID: DRC TERM-ID: GD8D

ACCT#	AMOUNT	K/L	CLM/CNT	BUDGET CODE
[redacted]	$2,155.39	PIPM	01	

11-16
3-28-07
pd
Hosp
pd. to Woodland Hgts. Hospital [redacted]
3-28-07

PF1:HELP PF3:RETURN PF7:BWD PF8:FWD

93 - Dodge P.U.



93 - Dodge 8.2L

93 Dodge P.U.

93 Dodge P.U.

To protect the privacy of individuals, NHTSA does not make medical records available to the public without authorization. For this reason, documents falling into this category have not been included in this complaint record.