

INFORMATION Redacted PURSUANT TO THE FREEDOM OF

 U.S. Department of Transportation National Highway Traffic Safety Administration		INFORMATION ACT (FOIA), 5 U.S.C. 552(B)(6) 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 08-JAN-2016 MAR 14 2016	Repository ☐ Reference No. 10819069		
OWNER INFORMATION (Type or Print)					
Name		Address		Daytime Telephone Number	E-mail Address
City		State	Zip Code	Evening Telephone Number	
ALBERTA		AL			
The information you provide will be used to identify potential safety-related defects. We may share your information with the applicable vehicle manufacturer during an investigation or recall in accordance with the routine uses described in the agency's Privacy Act notice. See 49 FR 53971 (Sep. 3, 2004).					
VEHICLE INFORMATION					
17 digit Vehicle Identification Number Located at bottom of windshield on driver's side JM1BG2245M0		Make MAZDA	Model PROTEGE	Model Year 1991	
Date Purchased	Dealer's Name and Telephone Number		Engine: No: Cylinders	Fuel Type:	
Original Owner ☐	Dealer's City <i>Selma</i>	State <i>AL</i>	Zip Code		
Transmission Type	☐ Antilock Brakes ☐ Cruise Control	Powertrain	Multiple Failure:	Incident Date(s) 01-JAN-2008	
FAILED COMPONENT(S)/PART(S) INFORMATION					
Vehicle Component Codes: 150000 SEAT BELTS, 140000 AIR BAGS			Failure Mileage 90000	Failure Speed 45	
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: DOTM19ABC036)	☐ Original Equipment ☐ Prior Repair	Failure Location:			
Tire Component Code			Tire Failure Type:		
ADDITIONAL ITEMS TO BE COMPLETED WHEN REPORTING A CHILD SEAT FAILURE					
Make:	Date Manufactured:	Model No./Name:			
Seat Type:	Installation System:				
Child Seat Component Code:		Failed Part:			
APPLICABLE INCIDENT INFORMATION (Please describe in detail the incident(s), Failure(s), Crash(es), and injury(ies).)					
Crash ☒ Yes ☐ No	Fire ☐ Yes ☒ No	Number of Persons Injured 1	Number of Deaths 0	Reported to Police 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 1991 MAZDA PROTEGE. THE CONTACT STATED THAT WHILE DRIVING AT APPROXIMATELY 45 MPH DURING RAIN WEATHER CONDITIONS, THE VEHICLE WENT OVER A POTHOLE CAUSING THE CONTACT TO LOSE CONTROL OF THE VEHICLE AND STOPPING ON THE SHOULDER OF THE ROAD. THE CONTACT THEN ATTEMPTED TO DRIVE AND THE VEHICLE SPUN CRASHING THE FRONT OF THE VEHICLE INTO A TREE. THE SEAT BELT DETACHED AND THE CONTACT WAS RELEASED FROM THE REAR WINDOW. THE AIR BAGS DID NOT DEPLOY. THE VEHICLE WAS TOWED AND DEEMED DESTROYED. THE CONTACT RECEIVED KNEE, HEAD, AND BACK INJURIES WHICH REQUIRED MEDICAL ATTENTION. A POLICE REPORT WAS FILED. THE MANUFACTURER WAS NOT NOTIFIED OF THE FAILURE. THE APPROXIMATE FAILURE MILEAGE WAS 90,000. see: DAD Group for CD					
Include, if available: Police/Fire Department Report, Photos, and Repair Invoice. ATTACH ADDITIONAL SHEETS IF NECESSARY					
The Privacy Act of 1974-Public Law 93-579 This information is requested pursuant to authority vested in the National Highway Traffic Safety Act and subsequent amendments. You are under no obligation to respond to this questionnaire. Your response may be used to assist the NHTSA in determining whether a Manufacturer should take appropriate action to correct a safety defect. If the NHTSA proceeds with administrative enforcement or litigation against a manufacturer, your response, or a statistical summary thereof, may be used in support of the agency's action.					

12/31/09

Loan Inquiry

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CIF number: [REDACTED]

Phone: (H) [REDACTED]

Birth date: [REDACTED]

(B) [REDACTED]

Tax ID number: [REDACTED]

Loan type: SI SIMPLE INSTALLMENTS

Loan number: [REDACTED]

L

1 of 1

Past due Messages Insurance

Original loan amt	1,906.45
Current balance	1,266.26
Accrued interest	33.81
Late charges due	20.00
Current payoff	1,315.18
Payoff good thru	12/31/09
Next period payoff	.00

Int base/rate	365/365	16.000000%
Per diem		.55507
Other Charges		.00
Amt partially paid		.00
Last payment date	12/01/09	
F1=Addl functions	F3=Exit	
F6=Messages	F8=Maintenance	

Officer	JCM	JOSH MORGAN
Org date/Maturity	6/02/09	8/03/10
Loan term/remaining pmts	14 M /	9
Next payment due date		12/03/09
Next scheduled pay date		1/03/10
Payment amount		150.29
Princ & Int pmt		150.29
Escrow Payment Amt		.00
Current Amount Due		160.29
Amount Past Due		170.29
Total Amount Due		320.58
Payment type/freq	Int. included	1 M

More...

F4=Sweep Inquiry	F5=History
F9=Relationships	F24=More Keys

Loan Inquiry

ALBERTA AL

CIF number:

Phone: (H)

(B)

Birth date:

Tax ID number:

Loan type: SI SIMPLE INSTALLMENTS

Loan number: 9060205 L

1 of 1

Past due Messages Insurance

Original loan amt	1,906.45
Current balance	1,266.26
Accrued interest	33.81
Late charges due	20.00
Current payoff	1,266.26
Payoff good thru	12/31/09
Next period payoff	.00

Int base/rate	365/365	16.000000%
Per diem		.55507
Other Charges		.00
Amt partially paid		.00
Last payment date		12/01/09
F1=Addl functions	F3=Exit	
F6=Messages	F8=Maintenance	

Officer	JCM	JOSH MORGAN
Org date/Maturity	6/02/09	8/03/10
Loan term/remaining pmts	14 M /	9
Next payment due date		12/03/09
Next scheduled pay date		1/03/10
Payment amount		150.29
Princ & Int pmt		150.29
Escrow Payment Amt		.00
Current Amount Due		160.29
Amount Past Due		170.29
Total Amount Due		320.58
Payment type/freq	Int. included	1 M

More...

F4=Sweep Inquiry	F5=History
F9=Relationships	F24=More Keys

12/31/09

Loan Inquiry

Page 01 of 12 12:55:17

ALBERTA AL

CIF number:

Phone: (H)

(B)

Tax ID number:

Loan type: SI SIMPLE INSTALLMENTS

Loan number:

Birth date:

1 of 1

Past due Insurance

Original loan amt	230.68
Current balance	88.13
Accrued interest	3.18
Late charges due	20.00
Current payoff	111.31
Payoff good thru	12/31/09
Next period payoff	.00

Int base/rate	365/365	18.000000%
Per diem		.04346
Other Charges		.00
Amt partially paid		.00
Last payment date	12/01/09	
F1=Addl functions	F3=Exit	
F6=Messages	F8=Maintenance	

Officer	JCM	JOSH MORGAN
Org date/Maturity	8/10/09	1/03/10
Loan term/remaining pmts	5 M /	2
Next payment due date		12/03/09
Next scheduled pay date		1/03/10
Payment amount		50.00
Princ & Int pmt		50.00
Escrow Payment Amt		.00
Current Amount Due		51.44
Amount Past Due		70.00
Total Amount Due		111.44
Payment type/freq	Int. included	1 M

More...

F4=Sweep Inquiry	F5=History
F9=Relationships	F24=More Keys

Officer No. _____
Loan Type _____
Officer Initials: JCM

MOUNTAIN LIFE INSURANCE COMPANY
517 AIRWAY DRIVE, P.O. BOX 240
ALCOA, TENNESSEE 37701-0240
PHONE (800) 888-6542
GROUP CREDITOR-DEBTOR ONLY INSURANCE

Group Insurance Application Number
AL _____

PROPOSED INSURED DEBTOR _____		SOC. SEC. NO. _____	AGE _____	EFFECTIVE DATE MO <u>06</u> DAY <u>02</u> YR <u>09</u>
PROPOSED JOINT INSURED DEBTOR _____		SOC. SEC. NO. _____	AGE _____	DATE OF FIRST PAYMENT MO <u>07</u> DAY <u>03</u> YR <u>09</u>
STREET ADDRESS _____	CITY ALBERTA	STATE AL	ZIP CODE _____ 0000	
CREDITOR BENEFICIARY NAME AND ADDRESS THE CAMDEN NATIONAL BANK		SECOND BENEFICIARY NAME AND ADDRESS ESTATE		
PLAN OF INSURANCE (MAXIMUM TERM)	INITIAL AMOUNT OF INSURANCE	TERM OF INSURANCE	PREMIUM	
☐ Level Term Life - One Insured (60 Months)	\$ _____	_____ MONTHS	\$ _____	
☐ Level Term Life - Joint Insured (60 Months)	\$ _____	_____ MONTHS	\$ _____	
☒ Decreasing Term Life - One Insured (120 Months)	\$ <u>1,906.45</u>	<u>14</u> MONTHS	\$ <u>18.34</u>	
☐ Decreasing Term Life - Joint Insured (120 Months)	\$ _____	_____ MONTHS	\$ _____	
	/MO. BENEFITS			
☐ Benefit For Disability - (Insured Debtor Only) (60 Months)	\$ _____	_____ MONTHS	\$ _____	
☐ Gross Balance Plan	☒ Net Balance Plan	Interest Rate	Regular Monthly Payment	TOTAL PREMIUM
Amount of Balloon Payment (if any)	\$ _____	<u>16.000</u>	\$ <u>150.29</u>	\$ <u>18.34</u>
Total Disability Benefits commence with the first day of any continuous period of disability of more than 7 ☐ 14 ☐ 30 ☐ days duration occurring during the Term of Insurance.				

SINGLE PREMIUM CREDIT LIFE AND DISABILITY INSURANCE

INSURANCE SHALL BE EFFECTIVE ONLY FOR THE ABOVE MARKED COVERAGE FOR WHICH PREMIUM IS PAID

APPLICATION FOR GROUP CREDIT LIFE AND DISABILITY INSURANCE

This Application Is To Be Used Only In Cases Where Evidence Of Insurability Is Required

You have the option to buy this insurance from any Company or agent of your choice or to assign a policy, which you now have. It is understood that you freely apply for the coverage shown in the schedule above. Your Creditor may deduct the amount of premium for this insurance from the proceeds of your loan.

1. Have you been in a hospital for any observation, operation or treatment, or consulted or been treated by any physician or other medical practitioner during the past twelve (12) months?
2. Are you now disabled, receiving treatment of any kind or contemplating an operation?
3. During the past ten years have you been treated for or advised by a licensed physician that you had any of the following: disease of heart, blood, lungs, liver, or kidneys; any mental, nervous, circulatory, or digestive disorder; high blood pressure; cancer or tumor; diabetes; drug or alcohol abuse; AIDS, ARC (AIDS Related Complex), or tested positive on an AIDS related blood test; disorder of the back, neck, spine or joints?
4. Are you currently working at least 30 hours per week?

Proposed Insured Debtor	Proposed Joint Insured Debtor
Height _____ Weight _____	Height _____ Weight _____
☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No

Your subsequent unemployment or retirement during the term of coverage will not be used to deny an otherwise valid claim.
(If the answer to any of the questions is yes, give details below)

Condition(s)	Date	Names, Addresses & Telephone Numbers of Attending Physicians

NOTE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I voluntarily apply for the insurance on the attached certificate. I declare and agree that to the best of my knowledge and belief the answers to the above questions are complete and true. Except as disclosed above, I certify that I am now free from any disease or physical impairment. I understand that this Application is subject to approval. If it is approved, the Application will become a part of the certificate to which it is attached. I also understand that the insurance certificate contains a pre-existing condition exclusion for disability insurance coverage. Upon acceptance of the insurance and within 30 days of the incurred indebtedness, the Insurer shall cause a certificate of insurance to be delivered to me. If the insurance is not approved, any premium paid will be refunded. However, if a valid claim arises before action has been taken, consideration of this Application for approval will continue as if no claim has been incurred.

AUTHORIZATION

I hereby authorize any individual, physician, medical practitioner, hospital, clinic or other medical related facility, Medical Information Bureau, insurance company, consumer reporting agency, rehabilitative assessment agency or government authority to furnish Mountain Life Insurance Company, its reinsurers or their representatives any information related to the health, medical history, diagnosis, and treatment (including copies of records) concerning the above referenced individual. These records should include any treatment regarding alcoholism, drug abuse, AIDS, HIV testing, AIDS related illness and psychiatric care or any physical or mental condition and/or treatment rendered. A Photocopy of this authorization shall be considered as valid as original. This authorization shall be valid for a period of one year from the date of signature.

PROPOSED INSURED DEBTOR	PROPOSED JOINT INSURED DEBTOR
Date of Birth _____ Birthplace (State) _____	Date of Birth _____ Birthplace (State) _____
Month/Day/Year _____	Month/Day/Year _____
Occupation _____	Occupation _____
Signature _____ Date _____	Signature _____ Date _____
Witness _____ Creditor/Agent	Not Eligible For Disability Insurance

FOR HOME OFFICE USE ONLY

Approved _____ By _____
Declined _____ Date _____



When taking any medication, you should know what to expect. That's why we include with every prescription. It's written information on dosage, side effects, potential drug interactions. If you have questions after reading the talk to your Rite Aid Pharmacist or your pharmacist. With us, it's personal.

03/02



100

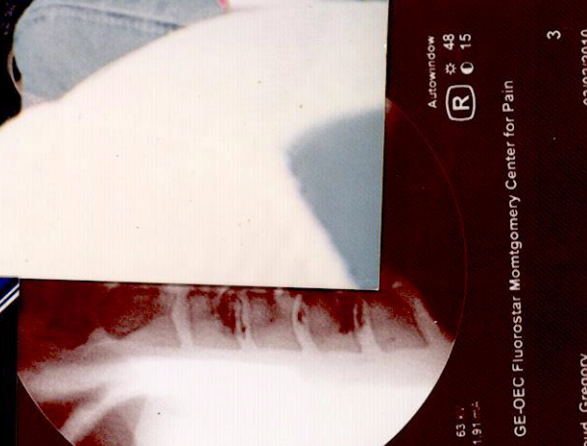
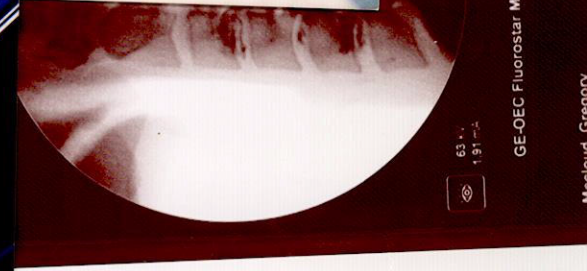
We give it to you in writing

When taking any medication, you should know exactly what to expect. That's why we include Rite Advice with every prescription. It's written information on dosage, side effects, potential drug interactions and more. If you have questions after reading this, please talk to your Rite Aid Pharmacist or your physician.

03/02



10



86 x .
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67° 50' 12" N
112° 54' 12" W

Autowindow
50
12

(R)

GE-OEC Fluorostar Multimetry Center for Pain

63-11
1.31-1.4

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.

FROM:

[REDACTED]
ALBERTA AL. [REDACTED]
[REDACTED]
[REDACTED]



TO:

US Department of Transportation
National Highway Traffic Safety Administration
Office of Defects Investigation,
1200 New Jersey Avenue SE.
Washington, D.C. 20077-9382

W48-226

20590

Utility Mailer
10 1/2" x 16"

Ready **P**ost.

To protect the privacy of individuals, NHTSA does not make Video's that contain Personal Identifying Information available to the public without authorization. For this reason, Video's falling into this category have not been included in this complaint records