

T:

(b)(6)

07I57T002

(b)(2)High

Filed: 20 Dec 06

(b)(3),(b)(6)

10,000

## CLAIMS CHRONOLOGY SHEET

CLAIMANT'S NAME:

(b)(6)

FILE NUMBER: 07I57T002

AMOUNT CLAIMED: \$10,000

DATE OF INCIDENT: 29 Aug 05 AT:

DATE CLAIM FILED: 20 Dec 06

DATE	STATUS OF CASE	INITIALS
12/20/06	Loggin in; To CPT Bartleson for review	TH
(b)(2)High, (b)(5)		(b)(3)(b)(6)
12/22	pending payment → To CPT for signature	
1/13	PAID TO CLAIMANT IN FULL	
1/16/07	Closed	



## Tort and Special Claims-Pro Version

Home | Search | Administrator | Reports | Log Out | Request Assistance  
SSG (b)(3)(b)(6) NCOIC of Client Services Wednesday, 17 January 2007

Open Claims - Claim Transaction - 07I57T002

(b)(6)

Quick Search

Go

(b)(6) 01-Oct-2006 - 30-Sep-2007

Current Month: 01-Jan-2007 - 31-Jan-2007

I57 - I57 (Iraq)

Add Transaction

Claim ID:	Owner Office:	End CEA Balance:
07I57T002	I57 - I57 (Iraq)	\$153,300.00 (request increase)
Action (required):		Action Date
Action Dollar Amount: \$		
0		
Add Transaction		

## Transactions for Claim 07I57T002

Del	Reason for Denial:				Date Added	
Edit	Action Date	Action Description	Action Office	Amount	T-ferred To	Initiated
<input checked="" type="checkbox"/>	12/18/2006	Open New Claim	I57 (Iraq)	\$0.00		
<input checked="" type="checkbox"/>	1/13/2007	Final Payment Claim Closed (Funds deducted CEA)	I57 (Iraq)	\$10,000.00		(b)(3),(b)(6)

Create DA FORM 7500, 1666, 1668, or SF 1034

Create FMS Forms

(b)(2)High

(b)(2)High



HEADQUARTERS  
MULTI-NATIONAL CORPS - IRAQ  
BAGHDAD, IRAQ  
APO AE 09342

REPLY TO  
ATTENTION OF:

FCC I57

22 December 2006

CLAIM OF: (b)(6)  
CLAIM NUMBER: 07-I57-T002

Dear Sir or Ma'am:

This notice constitutes final administrative action on your claim against the United States.

Foreign Claims Commission (FCC) I57 has investigated and considered the claim under the Foreign Claims Act (FCA), Title 10, United States Code, Section 2734, as implemented by Army Regulation (AR) 27-20, Chapter 10. The claim is cognizable solely under the FCA as it concerns an inhabitant of Iraq. The Federal Tort Claims Act, Title 28, United States Code, Section 2680(k), is not applicable as it excludes claims arising in foreign countries. Under the FCA, a claim for death or personal injury may be allowed whether or not the negligent act complained of was made within the scope of employment.

FCC I57 offers you \$10,000 to settle your claim. To accept this settlement offer, please sign and return the enclosed forms and an appointment will be made to meet you and to issue payment.

If you are dissatisfied by this action, AR 27-20 provides that you may request that the decision be reconsidered. Any such request must be forwarded to this office for FCC consideration. There is no prescribed format for such a request. However, it should describe the legal and/or factual basis for relief. Any request for reconsideration must be made, in writing, within 30 days of receipt of this letter.

The FCC's action on reconsideration is final and conclusive by law.

Sincerely,

(b)(3),(b)(6)

Captain, U.S. Army  
Foreign Claims Commission I57



REPLY TO  
ATTENTION OF:

HEADQUARTERS  
MULTI-NATIONAL CORPS – IRAQ  
BAGHDAD, IRAQ  
APO AE 09342

FICI-JA-C

Claim of [REDACTED] (b)(6) 07-I57-T002

ACTION

1. Facts: The claimant alleges that on 29 August 2005, U.S. Forces were shooting towards them as her family was headed to Jordan for medical treatment. The claimant and her husband ended up in the U.S. military hospital for treatment. Her husband had surgery and died. The amount requested is \$10,000 for the claim.
2. Opinion: The FCA permits compensation for damages caused by the negligent and wrongful acts of US forces. Upon review of the claim, payment is granted.
3. Authority: The Foreign Claims Act (10 U.S.C. § 2734) as implemented by AR 27-20, Chapter 10.
4. Action: The claim will be paid in the amount of \$10,000.

[REDACTED]  
(b)(3),(b)(6)

Captain, JA  
Foreign Claims Commission I57

UNCLASSIFIED/OFFICIAL USE ONLY

PAYMENT REPORT

TO: DFAS, DSSN \_\_\_\_\_ DATE: 13 Jan 07

A. Payment Data:

- (1) Submitting agency/office: United States Army Claims Service
- (2) Office Code: 157
- (3) Agency/Office mailing address: MNC-1, OSJA, Camp Victory, Iraq APO AE 09342
- (4) Date Filed: \_\_\_\_\_
- (5) Claim Number: 07-157-7002
- (6) Amount Claimed: \$10,000
- (7) Fund Cite: \_\_\_\_\_ (b)(2)High
- (8) Payee: \_\_\_\_\_
- (9) Address: IRAQ
- (10) SSN: N/A
- (11) Payment Amount: 10,000
- (12) Type Payment: PF
- (13) For EFT Payments: ABA Routing Number: \_\_\_\_\_
- (14) For EFT Payment: Account Name and Number: \_\_\_\_\_
- (15) For EFT Payment: Name and Address of financial institution: \_\_\_\_\_
- (16) For EFT Payment: Account is (checking) (savings) Circle appropriate account

B. Acceptance by Claimant: (Note: This form should not be signed by the claimant if another release is signed by the Claimant is attached.)

I, The claimant, do hereby accept the within - stated award, compromise, or settlement as final and conclusive on my heirs, executors, administrators or assigns; and agree that said acceptance constitutes a complete release by me, my heirs, executors, administrators or assigns of any and all claims, demands, rights, and causes of action of whatsoever kind in nature, arising now or in the future from, and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries (including wrongful death), damages to property, breaches of contract or law, and any other acts or omissions, and the consequences therefore resulting, and to result, from the same subject matter that gave rise to the claim by reason of the same subject matter. I further agree to reimburse, indemnify and hold harmless the United States, its agents, servants and employees from any and all claims or causes of action, including wrongful deaths, that arise or may arise from the acts or omissions that gave rise to the claim(s) by reason of the same subject matter.

Date: Foreign Language, (b)(6) (b)(6), Foreign Language (Claimant)

C. AGENCY CERTIFYING OFFICER

Pursuant to authority vested in me, I certify that this Payment Report is correct and proper for payment

13 Jan 07 (b)(3), (b)(6) FCC  
(Date) (Signature Authorizing Certifying Officer) (Title)

Date Payment Recorded in Record: 13 Jan 07

A separate payment report must be completed for each claimant

This information is required in accordance with 31 U.S.C. 1304. The data you furnish will be used to certify your claim for payment. Failure to provide the information may result in your claim not being processed for payment.

# 07-157-7002

قبول بالتوقيع من قبل المدعى (المطالب)

I, the claimant by signing this document and accepting payment, am releasing the United States Military and the United States Government from any further liability resulting from this claim and accepting this payment as final settlement on this claim.

أنا المدعي (المطالب) بالامضاء و بالتوقيع على تلك الاستمارة و الموافقة على العرض (المبلغ) أنا  
أنا ألتزم عن حقى الكامل و الإعفاء الكامل للقوات العسكرية الأمريكية أو حكومة الولايات المتحدة  
من أى مسئولية مقبلة تنتج من المطالب و الموافقة على المبلغ المعروض على أنه عرض  
و ليس من حقى وأو الوزنة من بدنى وأو أية شخص متضرر أو غير متضرر القيام بأى  
عمل قانونى أو غير قانونى ضد القوات العسكرية الأمريكية أو الولايات المتحدة الأمريكية فى  
المستقبل.

Foreign

Name of Claimant:

Amount Received: \$ 10,000.00

Date Received:

(b)(6)

Claimant's Signature:

OSJA POC: (DSN) 318-822-2864

b)(3),b)(6)

(PROVINCE'S)  
UNITED STATES ARMED FORCES CLAIMS FORM

I. TO: United States Army Foreign Claims Commission      Today's Date: 11/11/2003

II. FROM: Name (English):

Name (Arabic):

(b)(6), Foreign Language

(a) Circle one: Claimant / Attorney / Representative / Brother / Sister / Son / Daughter

→ [Attorney or representative MUST attach proof of authorization.] Other: \_\_\_\_\_

(b) IRAQI IDENTIFICATION NUMBER:

(b)(6)

(c) DETAINEE IDENTIFICATION NUMBER: \_\_\_\_\_

III. ADDRESS of person filing claim:

(English):

(Arabic):

(b)(6), Foreign Language

IV. HOME

(b)(6)

(a) I, the above named claimant/attorney/representative, certify that I (or the person on whose behalf I am making this claim) am a resident of \_\_\_\_\_.

(b) I hereby make a claim against the UNITED STATES GOVERNMENT for damages or injuries caused by the following military unit: \_\_\_\_\_

(c) The property damaged is owned by: her self

(d) The incident happened on 29/8/2003 at Remadi  
(Date) (city/town/neighborhood/highway name & number)

V. The facts of the incident are as follows: as she said. Her husband was driving & taken her and his daughter to get some medical treatment in Jordan.

near to Retba The U.S started shoot towards then she found herself in U.S military hospital and told her they are making a surgery for her husband. after finishing the operation he was dead. They apologized to her and gave her that report

[Use back of sheet if needed. Be sure to include any photographs, statements from witnesses, documents proving ownership of damaged or destroyed property, death certificates, medical bills and repair estimates.]



# UNITED STATES ARMED FORCES CLAIMS FORM

VI. The following is a detailed list of what was damaged or destroyed and the estimates for repair if damaged and replacement if destroyed:

ITEM	PRICE
death husband	\$ 10000
TOTAL \$ 10000	

- (a) I had insurance for the following: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- (b) My insurer is: \_\_\_\_\_

VII. My total claim in U.S. Dollars against the United States Government is: \$ 10000,  
and in Iraqi Dinars is: \_\_\_\_\_.

**\*\*\*CLAIM WILL NOT BE VALID IF US DOLLAR AMOUNT IS LEFT BLANK\*\*\***

This is my total claim resulting from this incident. I understand that if I accept a settlement of this claim that I will not receive any other money for this incident. I also understand that if my claim is denied I will have the opportunity to appeal the decision but will not have my claim approved.

(b)(6), Foreign Language

(Signature of Claimant)

**\*\*\*CLAIM WILL NOT BE VALID IF SIGNATURE IS LEFT BLANK\*\*\***

The claimant was assisted in completing this claim form by:

(b)(6)

(Name)

(Contact Information: e-mail, address, DSN/DNVT, etc.)

~~FOR OFFICIAL USE ONLY~~

TAB C (IRAQI CIVILIAN HANDOVER DOCUMENT) TO APPENDIX 9 (MORTUARY AFFAIRS) TO  
ANNEX I (SERVICE SUPPORT) TO 52 ID (M) OPOD 05-06-01



MULTI-NATIONAL FORCES - IRAQ

The Multinational Force-Iraq deeply regrets the loss of your loved one and wishes the return of the human remains of (b)(6) to his/her primary next of kin. The remains have been treated with the same respect and courtesies required by Muslim or Christian tradition and have been treated with the same respect and courtesy as those of the Coalition forces. The person receiving the remains acknowledges that Coalition forces have provided the remains in a respectful manner. Any perceived violation of local customs is wholly unintentional on the part of Coalition forces. All personal effects that were found with the remains are being turned over and an inventory is attached.

القوات المتعددة الجنسية - العراق تتقدم بكل الأسف العميق والأعتدار لفقدان احبابكم و تتمنى ان تقدم و ترجع اليكم البقايا الانمية الخاصة بالمرحوم الى نسب اهله القريب الاولى اليه. مع العلم بأن البقايا الانمية تم معاملتها بكل الاحترام والنطف التي تتطلبها تقاليد وعادات الديانة الاسلامية او الديانة المسيحية و تمت معاملتها بنفس المعاملة التي تلقاها الموتى من قوات التحالف. الشخص المسلم للبقايا الانمية يدرك جيدا بان قوات التحالف قامت بالعمل اللازم و بكل اساليب الاحترام التامة. و التقاليد المحلية فبكل الاسف انه ليس عمدا و غير مقصود كليا من جانب قوات التحالف. مع العلم جميع المتاع الشخصية التي وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

(b)(6)

(b)(6), Foreign Language

اسم الشخص للتأكد و اثبات البقايا الانمية  
Person verifying identity

WIFE & BROTHER

Foreign Language, (b)(6)

اسم الشخص المستلم  
Person receiving remains

(b)(6), Foreign Language  
العلاقة بالمرحوم  
Relationship to deceased

29 AUG 05

Foreign Language

التاريخ  
Date

I-IX-C-1

~~FOR OFFICIAL USE ONLY~~

CENTCOM 019853

07-I57-T002-00010

26457

Foreign Language, (b)(6)

CERTIFICATE OF DEATH (OVERSEAS) Acte de décès (D'Outre-Mer)					
NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms)		GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale	
(b)(6)		N/A	N/A	N/A	
ORGANIZATION Organisation		NATION (e.g., United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe	
IRAQI CITIZEN		IRAQ	(b)(6)	<input checked="" type="checkbox"/> MALE Masculin <input type="checkbox"/> FEMALE Féminin	
RACE Race		MARITAL STATUS État Civil		RELIGION Culte	
CAUCASOID Caucasique		SINGLE Célibataire		PROTESTANT Protestant	
NEGROID Nègre		<input checked="" type="checkbox"/> MARRIED Marié		CATHOLIC Catholique	
<input checked="" type="checkbox"/> OTHER (Specify) Autre (Spécifier) SOUTH WEST ASIAN		WIDOWED Veuf		JEWISH Juif	
NAME OF NEXT OF KIN Nom du plus proche parent		RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit			
STREET ADDRESS Domicile à (Rue)		CITY OF TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)			
MEDICAL STATEMENT Déclaration médicale					
CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)					INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Maladie ou condition directement responsable de la mort					GUN SHOT WOUND TO THE FACE - @ EYE
					0 3 HRS.
ANTECEDENT CAUSE Symptômes précurseurs de la mort	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire				
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire				
OTHER SIGNIFICANT CONDITIONS Autres conditions significatives					
MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée		CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures		
NATURAL Mort naturelle	<input type="checkbox"/> YES Oui <input checked="" type="checkbox"/> NO Non		GSW		
<input checked="" type="checkbox"/> ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie		N/A		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste				
HOMICIDE Homicide	SIGNATURE Signature		DATE Date	AVIATION ACCIDENT Accident à l'Avion	
				<input type="checkbox"/> YES Oui <input type="checkbox"/> NO Non	
DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)		PLACE OF DEATH Lieu de décès			
1753 29 AUGUST 2005		'CHARLIE MED' 228 <sup>TH</sup> FSB CAMP RAMADI, IRAQ			
I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE. J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.					
NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire		TITLE OR DEGREE Titre ou diplôme			
DR. (b)(3), (b)(6)		MEDICAL CORP PHYSICIAN			
GRADE Grade		BATTALION			
LTC		(b)(3), (b)(6)			
DATE Date		LTC			
29 AUG 05					

(b)(6), Foreign Language

(REMOVE, REVERSE, AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

3

DISPOSITION OF REMAINS			
NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER
INSTALLATION OR ADDRESS	DATE	SIGNATURE	
NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY		
TYPE OF DISPOSITION <input type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)		DATE OF DISPOSITION	
REGISTRATION OF VITAL STATISTICS			
REGISTRY (Town and Country)	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER
NAME OF FUNERAL DIRECTOR	ADDRESS		
SIGNATURE OF AUTHORIZED INDIVIDUAL			

DD FORM 2064, APR 1977 (BACK)

USAPA V1.00

Standard Form 1034 Revised October 1987 Department of the Treasury 1 TFM 4-2000 1034-121		<b>PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL</b>				VOUCHER NO.	
U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION <b>DEPARTMENT OF THE ARMY 15th Finance Battalion Camp Liberty, Iraq APO AE 09344 DSSN</b>				DATE VOUCHER PREPARED		SCHEDULE NO.	
				CONTRACT NUMBER AND DATE		PAID BY <b>15th Finance Company Camp Liberty, Iraq APO AE 09344 DSSN: 5779</b>	
				REQUISITION NUMBER AND DATE			
<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 5px; margin-right: 10px;">PAYEE'S NAME AND ADDRESS</div> <div style="border: 1px solid black; padding: 10px; flex-grow: 1;"> <div style="text-align: center;">(b)(6)</div> <div style="text-align: center; font-weight: bold;">07157T002</div> </div> </div>				DATE INVOICE RECEIVED			
				DISCOUNT TERMS			
				PAYEE'S ACCOUNT NUMBER			
				SHIPPED FROM		TO	
NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES <i>(Enter description, item number of contract or Federal supply schedule, and other information deemed necessary)</i>	QUAN- TITY	UNIT PRICE COST      PER		AMOUNT (1)	
		<b>Claim Payment</b> <b>Final Payment of FCA Claim#</b>  In full settlement of the amount allowed by the Secretary of the Army, or an officer duly designed for such purposed under authority of 31 U.S.C 3721 and AR 27-20, Chapter 10, upon the claim of the above named claimant for property damaged, lost, destroyed, captured, or abandoned in service.	1			\$10000	
(Use continuation sheet(s) if necessary)				<b>(Payee must NOT use the space below)</b>		<b>TOTAL</b> 10,000	
PAYMENT: <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> COMPLETE <input type="checkbox"/> PARTIAL <input checked="" type="checkbox"/> FINAL <input type="checkbox"/> PROGRESS <input type="checkbox"/> ADVANCE		APPROVED FOR <div style="text-align: center;">L      \$ 10000</div> BY: (b)(3),(b)(6) MSG  TITLE Pay Agent	EXCHANGE RATE <div style="text-align: center;">=\$1.00</div>	DIFFERENCES			
				Amount verified; correct for			
				(S) (b)(3),(b)(6)			
Pursuant to authority vested in me, I certify that (b)(3),(b)(6) is the authorized certifying officer.							
13 JAN 07 (Date)		(b)(3),(b)(6) (Authorized Certifying Officer) 1		CPT, Certifying Officer 157160 (Title)			
ACCOUNTING CLASSIFICATION							
(b)(2)High							
Account Classification Verified: 1st CAV, 15th Finance Office, Disbursing NCOIC							
PAID BY	CHECK NUMBER	ON ACCOUNT OF U.S. TREASURY		CHECK NUMBER	NAME (Name of bank)		
	CASH	DATE	PAYEE	(b)(6)			
	\$						
1 When stated in foreign currency, insert name of currency. 2 If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the space provided, over his official title. 3 When a voucher is receipted in the name of a company or corporation, the name of the person writing the company or corporate name, as well as the capacity in which he signs, must appear. For example: "John Doe Company, per John Smith, Secretary," or "Treasurer," as the case may be.				TITLE			

Previous edition usable

**PRIVACY ACT STATEMENT**  
The information requested on this form is required under the provisions of 31 U.S.C. 82b and 82c, for the purpose of disbursing Federal money. The information requested is to identify the particular creditor and the amounts to be paid. Failure to furnish this information will hinder discharge of the payment obligation.

NSN 7540-00-900-2234  
USAPPC V1.00

CENTCOM 019858

07-157-T002-00015

26462

Foreign Language, (b)(6)



7

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov. 1943 (SSN).

**DISCLOSURE:** Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however, may result in improper identification of the deceased person and person making visual identification.

[illegible]

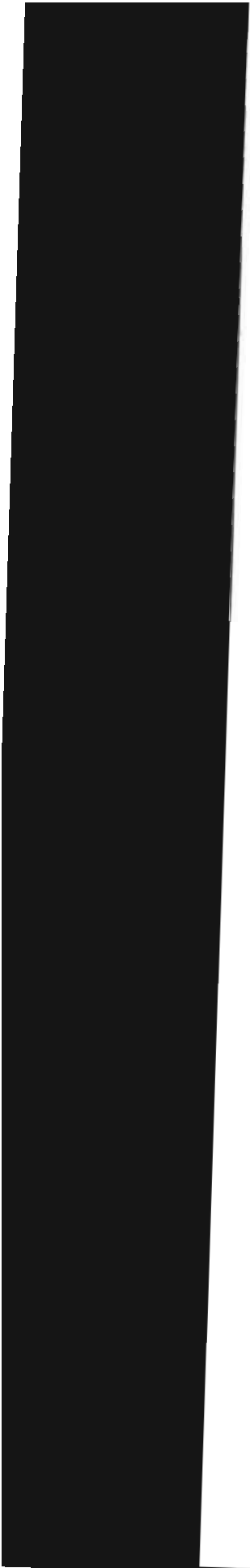
PREVIOUS EDITION MAY BE USED.

USAPA 9V-1 220

(b)(6), Foreign Language

Pages 19 through 22 redacted for the following reasons:

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Foreign Language, (b)(6)  
Nonresponsive



Foreign Language

(b)(6), Foreign Language

Foreign Language

(b)(6), Foreign Language

[Redacted]

Pages 24 through 25 redacted for the following reasons:

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(b)(6), Foreign Language  
Foreign Language, (b)(6)

Foreign Language, (b)(6)

(b)(6), Foreign Language

Foreign Language, (b)(6)

Page 28 redacted for the following reason:

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(b)(6)