

T: [redacted] (b)(6)

07157T002

[redacted] (b)(2)High

Filed: 20 Dec 06

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

10,000
#



Tort and Special Claims-Pro Version

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SSG (b)(3)(b)(6) NCOIC of Client Services Wednesday, 17 January 2007

Open Claims - Claim Transaction - 07157T002

(b)(6)

Quick Search

(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:
07157T002	I57 - I57 (Iraq)	\$153,300.00 (request increase)
Action (required):	Action Date	

Action Dollar Amount: \$

0

Add Transaction

Transactions for Claim 07157T002

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

(b)(2)High

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

Create FMS Forms

(b)(2)High



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

REPLY TO
ATTENTION OF:

FCC 157

22 December 2006

CLAIM OF:
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) 157 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 157 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,

Captain, U.S. Army
Foreign Claims Commission 157



REPLY TO
ATTENTION OF:

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

FICI-JA-C

Claim of [REDACTED] (b)(6) 07-157-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~~

CENTCOM 019848

07-157-T002-00005

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 المدع (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) أيا
المتعلق به عن حتى الكامل و الاعناء الكامل للقوات العسكرية الأمريكية أو حكومة الولايات المتحدة
من أي مسئولية مقبلة تنتج من المطالب و الموافقة على المبلغ العروض على انه عرض
و ليس من حتى وأل الورثة من بعدى وأل اية شخص منضمر أو غير منضمر القيام بأى
عمل قانونى أو غير قانونى ضد القوات العسكرية الأمريكية أو الولايات المتحدة الأمريكية فى
المستقبل.

Name of Claimant:

Amount Received: \$ 10,000.00

(b)(6)

Date Received:

OSJA POC: (DSND) 318-822-2864

Claimant's Signature:

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

~~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 والأعداد لفقدان احبايكم و تتمنى ان تقدم و ترجع اليكم البقايا الادمية الخاصة بالمرحوم الى نسب اهله القريب الاولى الية. مع العلم بأن البقايا الادمية 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 الادمية يدرك جيدا بان قوات التحالف قامت بالعمل اللازم و بكل اساليب الاحترام التامة. و في حالة وجود او ادراك أية انتهاك للعادات و التقاليد المحلية فيكل 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 الادمية
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~~

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 Négréide		<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 CAUSES 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 <input type="checkbox"/> YES Oui <input checked="" type="checkbox"/> NO Non		CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures	
NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie		GSW	
<input checked="" type="checkbox"/> ACCIDENT Mort accidentelle	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 TH 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)		LTC	
DATE Date				
29 AUG 05				
<small>1. State disease, injury or complaint. 2. State conditions contributing to death. 3. Preciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc. 4. Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou la condition qui a provoqué la mort.</small>				

(b)(6), Foreign Language

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

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 County)	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		PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL				VOUCHER NO.
U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION DEPARTMENT OF THE ARMY 15th Finance Battalion Camp Liberty, Iraq APO AE 09344 DSSN			DATE VOUCHER PREPARED		SCHEDULE NO.	
			CONTRACT NUMBER AND DATE		PAID BY 15th Finance Company Camp Liberty, Iraq APO AE 09344 DSSN: 5779	
			REQUISITION NUMBER AND DATE			
PAYEE'S NAME AND ADDRESS [(b)(6)] 07I57T002			DATE INVOICE RECEIVED			
			DISCOUNT TERMS			
			PAYEE'S ACCOUNT NUMBER			
			GOVERNMENT B/L NUMBER			
SHIPPED FROM		TO		WEIGHT		
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>	QUANTITY	UNIT PRICE COST PER	AMOUNT (!)	
		Claim Payment Final Payment of FCA Claim# In full settlement of the amount allowed by the Secretary of the Army, or an officer duly designed for such purposes 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) (Payee must NOT use the space below)					TOTAL	10,000
PAYMENT:		APPROVED FOR	EXCHANGE RATE	DIFFERENCES		
<input type="checkbox"/> PROVISIONAL		1 = \$ 10000	= \$1.00			
<input type="checkbox"/> COMPLETE		BY:				
<input type="checkbox"/> PARTIAL		(b)(3),(b)(6) MSG				
<input checked="" type="checkbox"/> FINAL		TITLE		Amount verified; correct for		
<input type="checkbox"/> PROGRESS		Pay Agent		(S) (b)(3),(b)(6)		
<input type="checkbox"/> ADVANCE						
Pursuant to authority vested in me, I certify that		(b)(3),(b)(6)		CPT, Certifying Officer 157/160		
13 JAN 07 (Date)		(Authorized Certifying Officer) 2		(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	ON (Name of bank)		
	CASH	DATE	PAYEE	(b)(6)		
			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

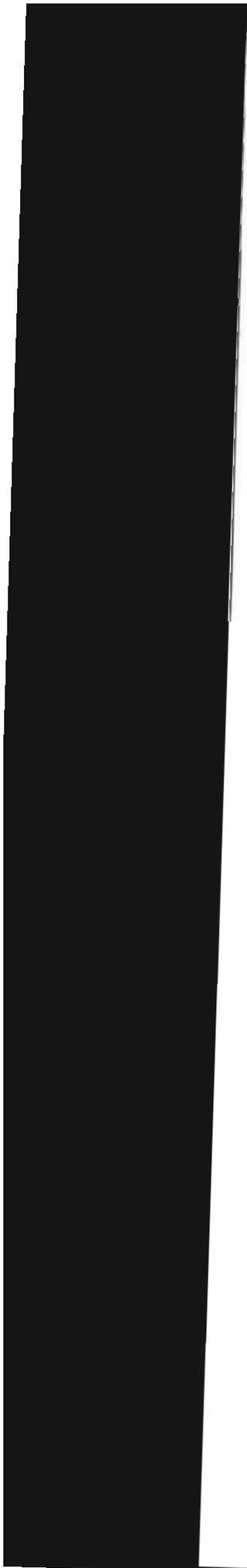
Foreign Language, (b)(6)

(b)(6), Foreign Language

Pages 19 through 22 redacted for the following reasons:

Foreign Language, (b)(6)

Nonresponsive



Foreign Language

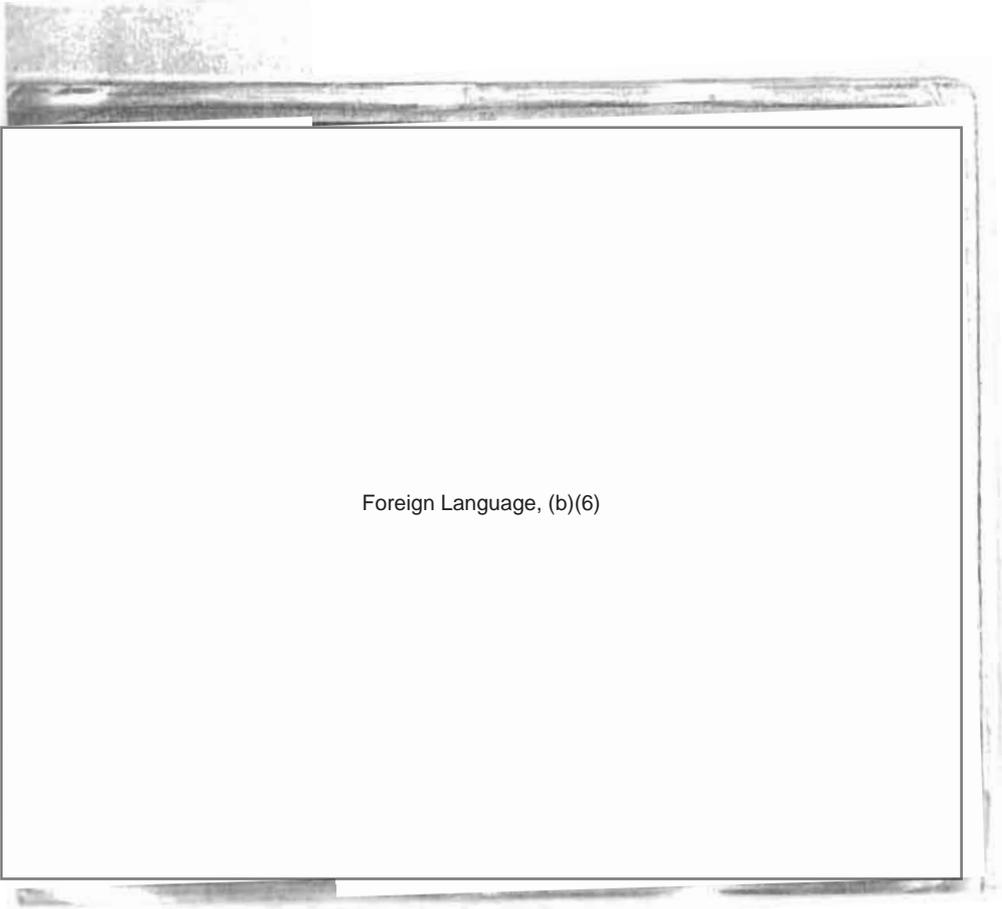
(b)(6), Foreign Language

Foreign Language

(b)(6), Foreign Language

Pages 24 through 25 redacted for the following reasons:

(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:

(b)(6)