PAYMENT REPORT

TO: DFAS, DSSN: 8724 Date: _____

A. Payment Data:

(1) Submitting Agency/Office: United States Army Claims Service

(2) Office Code: I5A

(3) Agency/Office Mailing Address: V Corps, OSJA Camp Victory, Iraq APO AE 09432

(4) Date Claim Filed: 1 September, 2003

(5) Claim Number(s) 04-I5A-T040

(6) Amount Claimed: $0.00

(7) Fund Cite: 2142020 22-0204 P436099.22-4200 VIRQ F9206 S99999 APC 9609

(8) Payee(s): [redacted]

(9) Address: Annana Village, Hilla,

(10) SSN: N/A

(11) Payment Amount: $1,000.00

(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 and 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 for which I or my heirs, executors, administrators, or assigns, and each of them, now have or may hereafter acquire against the United States and against the employee(s) of the Government whose acts or omissions 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: _____, ____ [redacted] (Claimant)

C. AGENCY CERTIFYING OFFICER:

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

(Date)	(Signature Authorized Certifying Officer)	FCC Title

Date Payment Recorded in Claim Record: _____

A separate payment report must be completed for each claimant

Privacy Act Statement

The 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 this information may result in your claim not being processed for payment.