NFLPA Response to Questions of October 12, 2007

EXHIBIT

B

Bert Bell/Pete Rozelle NFL Player Retirement Plan

Line of Duty Disability Benefits
Physician's Report Form

Notice to Physicians: To preserve your independence and the integrity of the decision-making process, you must avoid all contacts with attorneys or other representatives of the player seeking disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan. Please notify Rose Mary Eves or Paul Scott at the Plan Office (Tel. No. (800) 638-3186) immediately if you are contacted by any of these individuals.

To Be Completed By Plan Office:

1. Player's Name ____________________ Date of Birth ____________________

2. Address ____

3. Credited Seasons ____________________ Telephone ____________________

4. When did you first examine the player? ________________________________

5. Have you or have any of your partners ever treated the player? Yes _____ No _____

6. What is the nature of the impairment? ________________________________

____

7. Impairment Information (attach additional sheets if necessary)

Impairment To:	Impairment results from:	Does illness or injury result from football?	Has the impairment persisted or is it expected to persist for at least 12 months from the date of its occurrence?
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined

8. For Orthopedic Impairments:

Please rate the impairment percentage using the AMA's Guides to the Evaluation of Permanent Impairment (5th Edition) ("AMA Guides") by completing the detailed orthopedic evaluation impairment form for the impaired body parts. Copy the final impairment percentage ratings from those forms here. Record percentages as the BODY PART IMPAIRMENT ("BPI") for upper and lower extremity impairments only, and WHOLE PERSON IMPAIRMENT ("WPI") for spine impairments only. You may award up to three (3) percentage points for excess pain, in accordance with the AMA Guides. Do not use the range of motion test to evaluate spine impairments. Calculate the whole person impairment rating of the upper and lower extremity without regard to pain by multiplying the % BPI by .6 for the upper extremity and by .4 for the lower extremity.

	% BPI	+	Pain	=	Total	%WPI	
Upper Extremity	_____		_____		_____	_____	(BPI x .6)
Lower Extremity	_____		_____		_____	_____	(BPI x .4)

	% WPI	+	Pain	=	Total
Cervical Spine	_____		_____		_____
Thoracic Spine	_____		_____		_____
Lumbar Spine	_____		_____		_____

If player has impairments to multiple body parts, please combine the impairment ratings using the Combined Values Chart beginning on page 604 of the AMA Guides. If you are combining more than two WPI ratings, you will need to use the table more than once. DO NOT include additional percentage points for pain in the combination process.

Combined WPI % Impairment _____

You may award up to three (3) percentage points for excess pain.

Pain Rating _____%

9. For Non-Orthopedic Impairments:

Please rate the loss of use of hearing, speech, and sight:

Hearing: _____ 0-29% _____ 30-54% _____ 55-79% _____ 80% or greater
Speech: _____ 0-29% _____ 30-49% _____ 50-69% _____ 70% or greater
Sight: _____ 0-29% _____ 30-49% _____ 50-69% _____ 70% or greater

10. Is the player's condition the primary or contributory cause of the surgical removal or major functional impairment of a vital bodily organ or part of the central nervous system?

(A) Yes _____ (B) No _____

If your answer is "Yes", please identify the affected body part and describe the nature of the surgical removal or the major functional impairment.

_____

_____

11. Has the player's impairment improved since the last examination? DO NOT ANSWER if "N/A" appears in the blanks below. If you have not previously examined this player, the Plan Office will forward a copy of the Plan's last examination of this Player for your review.

Yes ____ No _____ N/A _____

12. Additional remarks by physician_____

_____

Please attach the required Medical Report and body part impairment rating forms.

Physician's Name (typed or printed):_____

Address _____

_____

Telephone _____

I certify that I have personally examined this Player and have personally reviewed any and all records of this Player given to me, and have personally reviewed the attached narrative reports. I also certify that my ratings and comments reflect my best professional judgment, and that I am not biased toward or against this Player.

Signature _____ Examination Date _____

Mail completed form with your narrative report to Rose Mary Eves at the Bert Bell/Pete Rozelle NFL Player Retirement Plan, 200 St. Paul Place, Suite 2420, Baltimore, MD 21202-2040.

Bert Bell/Pete Rozelle NFL Player Retirement Plan

Total and Permanent Disability Benefits
Physician's Report Form

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To Be Completed By Plan Office:

1. Player's Name ____________________ Date of Birth ____________________

2. Address ____

3. Credited Seasons ____________________ Telephone ____________________

4. When did you first examine the player? (Date)______________________________

5. Have you or have any of your partners ever treated the player ? Yes __No__

6. What is the nature of the impairment?______________________________________

____

7. Impairment Information (attach additional sheets if necessary)

Impairment To:	**Impairment results from:**	**Does illness or injury result from football?**	**Has the impairment persisted or is it expected to persist for at least 12 months from the date of its occurrence?**
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined
	❑ Illness ❑ Injury ❑ Unknown	❑ Yes ❑ No ❑ Cannot be determined	❑ Yes ❑ No ❑ Cannot be determined

8. In your opinion, is the player totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit?

(A) Yes _____ (B) No _____

If you checked (A), how long do you estimate the player will be unable to be gainfully employed at any occupation?

_____

If you checked (B), in what type of employment can he engage?

_____

_____

9. Additional remarks by physician_____

_____

Please attach the required Medical Report with this form.

Physician's Name (typed or printed):_____

Address _____

_____

Telephone _____

I certify that I have personally examined this Player and have personally reviewed any and all records of this Player given to me, and have personally reviewed the attached narrative reports. I also certify that my ratings and comments reflect my best professional judgment, and that I am not biased toward or against this Player.

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Bert Bell/Pete Rozelle NFL Player Retirement Plan

Both Line of Duty and Total and Permanent Disability Benefits Physician's Report Form

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To Be Completed By Plan Office:

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2. Address ____

3. Credited Seasons ____________________ Telephone ____________________

4. When did you first examine the player? ________________________________

5. Have you or have any of your partners ever treated the player? Yes _____ No _____

6. What is the nature of the impairment? ________________________________

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7. Impairment Information (attach additional sheets if necessary)

Impairment To:	**Impairment results from:**	**Does illness or injury result from football?**	**Has the impairment persisted or is it expected to persist for at least 12 months from the date of its occurrence?**
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Lower Extremity	_____		_____		_____	_____ (BPI x .4)

	% WPI	+	Pain	=	Total
Cervical Spine	_____		_____		_____
Thoracic Spine	_____		_____		_____
Lumbar Spine	_____		_____		_____

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11. Is the player's condition the primary or contributory cause of the surgical removal or major functional impairment of a vital bodily organ or part of the central nervous system?

Yes _____ No _____

If your answer is "Yes," please identify the affected body part and describe the nature of the surgical removal or the major functional impairment.

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12. Has the player's impairment improved since the last examination? DO NOT answer if "N/A" appears in the blanks below. If you have not previously examined this player, the Plan Office will forward a copy of the Plan's last examination of this Player for your review.

Yes ____ No _____ N/A _____

13. Additional remarks by physician _____

_____

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Physician's Name (typed or printed):_____

Address _____

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