

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

UNION COUNTY COUNSEL
RECEIVED

ADMINISTRATION BUILDING
ELIZABETH, NJ

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Leak, Orzie

Last Name, First, Middle

2/14/1934

Date of Birth

Street Address/Mailing Address

City, State Zip Code

Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name: Fredric L. Marcus, Esq.
Robert Treat Center
50 Park Place - 11th Floor
Newark, NJ 07102

Mailing Address:

City, State Zip Code

Relationship to claimant: Attorney at Law or

Explain Relationship

* Redactions made
to home address
and Social Security

to all TCN's
attached hereto.

3. The occurrence or accident which gave rise to this claim:

A. Date *11/3/2010* Time

B. Describe the location or place of the accident or occurrence

Hillside

Municipality

33 Quabeck Avenue

Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

Illegal entry and confiscation of all household contents at 33 Quabrock Ave, Hillside, by servants, agents & employees of Union County Sheriff's Dept., as a result of foreclosure at wrong address.

4. A. Claim for Damages (Check the appropriate block)

Personal Injury Property Damage

Other - Explain in detail *Anxiety attacks, loss of sentimental property, repayment (in dollar value) of all items illegally confiscated.*

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

See above.

B2. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent.

To be provided under separate cover.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

*JFK Medical Center
65 James St.*

b. Address

Edison, NJ

c. Dates of treatment or services

11/26 - 11/28/2010

d. Amount of charges to date

- To be supplied

e. Amount paid or payable by other sources such as insurance

Unknown @ present.

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

*Entire Contents of house at 33 Quabeck Ave, Hellside -
Complete list to be forwarded under separate cover.*

6. If you claim property damage:

A. Describe the property damage:

*Undetermined at present. Will provide
upon receipt of estimates.*

B. The present location and time when the property may be inspected:

See below

LOCATION	DATE	TIME
----------	------	------

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

*Public Storage
Hellside, NJ
Contact Ms. Leeks prior to
inspection.*

F. Description of damage.

To be supplied

G. Has the damage been repaired? NO

If yes, by whom, when and cost of repair.

Repaired by

When

Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

To be supplied

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Violation of person; destruction of property, emotional distress, mental anguish, inability to provide housing for family, furniture, destruction of items of sentimental value, loss of items of deceased daughter, etc.

B. The amount of the claim:

\$ 500,000 -

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Servants, agents & employees of Union County Sheriff's Dept and any and all others that a continuing investigation may reveal.

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

See 8A. - Ralph Froehlich - Sheriff

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Removal of property from the wrong premises. which caused - see #7

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

Green Source Services, REMAX, Realtors Village Square,
Wells Fargo Bank

11. State the names and address of all witnesses to the accident or occurrence.

Name of Witness Address

Name of Witness Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Personnel of _____
Union County Sheriff's Dept. Police Department
Name of Police Officer
Name of Police Officer _____
Police Department

B. Copy of Police Report attached:
 Yes No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

See # 10

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

Waiting for insurance information Will provide

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

Unknown at present

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

See #13

<u>Name & Address of Ins. Co.</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>
<u>Name & Address of Ins. Co.</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

() Yes No

If so, set forth the details of such agreement.

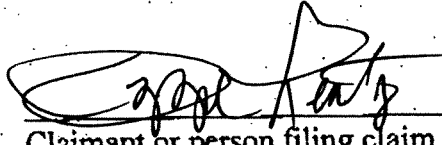
16. The following items must be submitted with this notice:

- A. Copies of itemized bills for each medical expense and other losses and expenses claimed.
- B. Full copies of all appraisals and estimates of property damage claims by you.
- C. Copies of all written reports of all expert witnesses and treating physicians.
- D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.
- E. Completed "Authorization for Release of Health Information", see attached form.

(A) - (D) To be supplied
E - Attached

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED:



Claimant or person filing claim on
behalf of claimant.

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

UNION COUNTY, NJ
RECORDS
JUL 14 2011
ADMINISTRATIVE
CLERK

1. Claimant:

Williams Tony
Last Name, First, Middle

12-05-73
Date of Birth

[REDACTED]
Street Address/Mailing Address

[REDACTED]
City, State Zip Code

[REDACTED]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name FREEMAN + BASS COUNSELLORS AT LAW

Mailing Address 24 COMMERCIAL STREET SUITE 726

City, State Zip Code NEWARK NJ 07102

Relationship to claimant: Attorney at Law or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 12/29/10 Time Between 12:45 PM + 1:00 PM

B. Describe the location or place of the accident or occurrence

UNION NJ
Municipality

1670 WALKER AVE
Exact location of the occurrence

X

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

CLAIMANT WAS OUTSIDE THE PROPERTY 1670 WALKER AVE WHEN HE
SLIPPED + FELL DUE TO SNOW + ICE ON THE SIDEWALK.

4. A. Claim for Damages (Check the appropriate block)

Personal Injury Property Damage

Other - Explain in detail _____

MEDICAL EXPENSES

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

ORTHOPEDIC, NEUROLOGICAL, PSYCHONEUROLOGICAL INJURIES.

B2. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent.

TO BE DETERMINED

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

DR I. AHMAD

b. Address 45 ACADEMY STREET 2ND FL. NEWARK, NJ 07102

c. Dates of treatment or services 01-05-11 UNTIL PRESENT.

d. Amount of charges to date TO BE DETERMINED

e. Amount paid or payable by other sources such as insurance

TO BE DETERMINED

B4. If you claim loss of wages or income as a result of the injury, state

Unemployed
Name of Employer

Address of Employer

N/A
Your Occupation

Date of Employment

N/A
Rate of Pay

Dates of absence from work

Date returned to work N/A

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:

N/A

B. The present location and time when the property may be inspected:

N/A
LOCATION

N/A
DATE

TIME

C. Date property was acquired.

N/A

D. Cost of property.

E. Value of property at time of accident.

N/A

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

To Be Determined

11. State the names and address of all witnesses to the accident or occurrence.

SLEDAH WILLIAMS

Name of Witness

1670A WALKER AVE

Address UNION NJ.

Name of Witness

Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

NONE
Name of Police Officer

Police Department

Name of Police Officer

Police Department

B. Copy of Police Report attached:

Yes No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

To Be Determined

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

To Be Determined

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

NO

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

<u>TO Be DETERMINED</u>	_____	_____
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
_____	_____	_____
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

() Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

- A. Copies of itemized bills for each medical expense and other losses and expenses claimed.
- B. Full copies of all appraisals and estimates of property damage claims by you.
- C. Copies of all written reports of all expert witnesses and treating physicians.
- D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.
- E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 1/11/11

X Tony Williams
Claimant or person filing claim on
behalf of claimant.

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Karim Ali 7/19/81
Last Name, First, Middle Date of Birth

1254 Clinton Place, Apt. C *claimant is presently
in incarcerated in Essex
County Jail*
Street Address/Mailing Address

Elizabeth, NJ 07202 [REDACTED]
City, State Zip Code Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name Dean R. Magliore, Esq.

Mailing Address 50 Park Place, suite 1400

Newark, NJ 07102
City, State Zip Code

Relationship to claimant: Attorney at Law () or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. 9/24/10 8:48
Date Time

B. Describe the location or place of the accident or occurrence

Union County 530 Vine St., Elizabeth, NJ
Municipality Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

See answer to C. of Tort Claim Notice previously supplied.

4. A. Claim for Damages (Check the appropriate block)

Personal Injury Property Damage
 Other - Explain in detail _____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

A broken leg and multiple gunshot wounds to the left chest, abdomen and right knee.

B2. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent.

Has RSD IN LEFT AS A RESULT OF SHOOTING.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state: Grat. UNION J, few days later University Hospital, early November East Orange General

a. Name of Hospital, Doctor or other Facility

see attached medical records.

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer

Address of Employer

Your Occupation

Date of Employment

N/A

Rate of Pay

Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

Personal Injuries. \$ 10,000,000.00

6. If you claim property damage:

A. Describe the property damage:

N/A

B. The present location and time when the property may be inspected:

LOCATION

DATE

TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

Repaired by

When

Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Personal injuries

B. The amount of the claim.

\$10,000,000.00

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Employees, servants and/or agents of the City of Elizabeth and its Police Department, the County of Union, and the State of New Jersey

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

Presently unidentified Elizabeth Police Officers, you may obtain further information regarding the specific identities of the shooters by contacting the Elizabeth Police Department.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Claimant was shot several times while fleeing from armed robbers and maliciously prosecuted

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

The city of Elizabeth

11. State the names and address of all witnesses to the accident or occurrence.

See Attached police report

Name of Witness

Address

Name of Witness

Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

William J. Deegan, JR

Name of Police Officer

Elizabeth

Police Department

Martha A. Rosales

Name of Police Officer

Elizabeth

Police Department

B. Copy of Police Report attached:

Yes () No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

The city of Elizabeth

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

not in possession of

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
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Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
----------------------------	---------------	--------------------------

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

() Yes No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

- A. Copies of itemized bills for each medical expense and other losses and expenses claimed.
- B. Full copies of all appraisals and estimates of property damage claims by you.
- C. Copies of all written reports of all expert witnesses and treating physicians.
- D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.
- E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED:

A handwritten signature in black ink, appearing to be "L. J. [unclear]", written over a horizontal line.

Claimant or person filing claim on
behalf of claimant.

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

UNION COUNTY COUNSEL
RECEIVED
10/11/2010 10:20 AM
DHW

1. Claimant:

Michael Higgs

06/08/1971

Last Name, First, Middle

Date of Birth

Street Address/Mailing Address

City, State Zip Code

Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name Ronald C. Hunt

Mailing Address 60 Park Place, 16th Floor, Newark, New Jersey 07102

City, State Zip Code

Relationship to claimant: Attorney at Law (X) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 11/10/2010 Time 9:00am

B. Describe the location or place of the accident or occurrence
SOMERSET COUNTY SOMERSET COUNTY SUPERIOR COURT

Municipality

Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

Claimant was unlawfully arrested and prosecuted in violation of his federal and state constitutional rights and those rights provided to Claimant by statute, regulation and/or policy governing law enforcement and prosecutorial entities.

See attached document.

4. A. Claim for Damages (Check the appropriate block)

Personal Injury Property Damage

Other - Explain in detail _____

civil rights violations, including false imprisonment, malicious prosecution and violations of due process

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

emotional distress related to anxiety stemming from the incidents which give rise to claimant's claim

B2. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent.

permanent emotional distress, anxiety, humiliation related to the actions taken against claimant by police and

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state: To be provided.

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state ^{N/A}

Name of Employer

Address of Employer

Your Occupation

Date of Employment

Rate of Pay

Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

Claimant was forced to incur expenses to defend against blatantly false accusations, including expenses related to polygraphs examinations, attorney's fees, voice analysis and posting bail in this matter.

6. If you claim property damage: ^{N/A}

A. Describe the property damage:

B. The present location and time when the property may be inspected:

LOCATION

DATE

TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

Repaired by

When

Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Violation of civil rights and intentional/negligent infliction of emotional distress, malicious prosecution and other related harm totaling \$5,000,000.00 and out-of-pocket expenses totaling approximately \$24,000.00. (See Paragraph 5)

B. The amount of the claim.

\$5,024,000.00

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Watchung Police Department 840 Somerset Street, Watchung, NJ 07069; Plainfield Police Department 200 E. 4th Street, Plainfield NJ 07061; Somerset County, 21 N. Bridge Street, Somerville, NJ 08876; Union County, Union County Administration Building, 15th Floor, Elizabethtown Plaza, Elizabeth, NJ 07207.

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

Detective Christopher Gelardi; W. Brian Stack ADA Somerset County

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

Wanton disregard by the within named agencies for federal and state constitutional protections afforded claimant. Failure to adhere to law enforcement and prosecutorial regulations, policy and/or procedure. Malicious investigation and prosecution of claimant where law enforcement blatantly lied and failed to properly investigate

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

At this time other persons involved in this matter are unknown to claimant, but will be provided when

11. State the names and address of all witnesses to the accident or occurrence.

Mary Higgs

[REDACTED]

Name of Witness

Address

Shante Griswell

[REDACTED]

Name of Witness

Address

Diane Griswell

[REDACTED]

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Detective Christopher Gelardi

Unknown

Name of Police Officer

Police Department

Name of Police Officer

Police Department

B. Copy of Police Report attached:

() Yes (X) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice. No.

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

N/A

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

Unknown.

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

<u>Name & Address of Ins. Co.</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>
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<u>Name & Address of Ins. Co.</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>
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15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

Yes No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

- A. Copies of itemized bills for each medical expense and other losses and expenses claimed.
- B. Full copies of all appraisals and estimates of property damage claims by you.
- C. Copies of all written reports of all expert witnesses and treating physicians.
- D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.
- E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED:

Michael Higgs 01-11-11
Claimant or person filing claim on
behalf of claimant.

December 30, 2010

Via Overnight Mail

Union County Counsel
Union County Administration Building, 15th Floor
Elizabethtown Plaza
Elizabeth, New Jersey 07207
Attn: Robert E. Barry, Esq.

Re: Notice of Tort Claim pursuant to N.J.S.A. 59:1-1, *et seq.*
Claimant: Michael Higgs
Date of Incident: November 10, 2010

Dear Sir or Madam:

This office represents the above-named Claimant with reference to an injury sustained on November 10, 2010, the date criminal charges against Claimant were dismissed. In or about January 2008, Claimant was travelling on Route 22 when he was pulled over, without probable cause, by an officer of the Watchung Police Department. Claimant was arrested and eventually transferred to Passaic County stemming from an arrest warrant. Upon information and belief, thereafter, the Watchung Police Department, without any supporting evidence, implicated Claimant in a drug operation allegedly based in Plainfield, New Jersey. Somerset County Investigators pursued Claimant to multiple addresses seeking to arrest him on these false accusations.

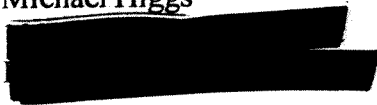
Claimant was arrested and charged with multiple drug related offenses under Indictment Number 09-03-204-I. Plainfield Police Department Officers, who were involved in the underlying narcotics investigation, and those persons/entities named and/or referenced above, continued to maintain Claimant's guilt despite the clear lack of evidence against Claimant and Claimant's production of evidence which exonerated him, including two (2) polygraph examinations, an expert voice analysis report and other information related to Claimant's whereabouts at the time of the subject incidents.

Claimant was incarcerated, forced to post bail, prosecuted for almost a two (2) year period, subjected to humiliation, and suffered other permanent personal injury as a direct and proximate result of the actions taken by the individuals/entities named and/or referenced herein. Such prosecution was deliberate, wanton, malicious and wholly without merit. Claimant's proclamations of innocence and multiple productions of exculpatory evidence were consistently ignored by those persons acting under color of law and charged with the fair and equitable application of the laws of the State of New Jersey.

On November 10, 2010, the Somerset County Prosecutor's Office was forced to dismiss the charges against Claimant on the basis that it could not prove the claims made by law enforcement officials. This letter is being sent to you to give you notice of Claimant's claim for injury, as required by N.J.S.A. 59:1-1, *et seq.*

1. Name and post office address of the Claimant:

Michael Higgs



2. The post office address to which the person presenting the claim desires notices to be sent.

See letterhead above.

3. The date, place and other circumstances of the occurrence or transaction which gave rise to the claim asserted:

See description above.

4. A general description of the injury, damage or loss incurred so far as it may be known at the time of the presentation of the claim:

Claimant was required to expend thousands of dollars to defend against claims and accusations made by persons acting under color of law who knew or should have known the charges against claimant were blatantly false. Notwithstanding, Claimant's production of numerous evidence which exonerated Claimant of the charges, the persons described and/or referenced herein maliciously prosecuted Claimant causing him to suffer permanent and debilitating personal injury, including but not limited to emotional distress.

5. The name or names of the public entity, employee or employees causing the injury, damage or loss, if known:

Somerset County, Union County, Plainfield Police Department, Watchung Police Department and employees, agents and/or servants of these entities and others whose names are presently unknown to Claimant.

6. The amount claimed as of the date of the presentation of the claim, including estimated amount of any prospective injury, damage, or loss, insofar as it may be known at the time of the presentation of the claim, together with the basis of the computation of the amount claimed.

Five million dollars (\$5,000,000.00).

If you have any special or specific forms upon which this claim must be presented, please forward those forms to the undersigned, without delay, and a more appropriate notice will be provided.

Very truly yours,
HUNT, HAMLIN & RIDLEY

Ronald C. Hunt



LAW OFFICE OF PAUL W. BERGRIN

A PROFESSIONAL CORPORATION

Certified Criminal Trial Attorney by the NJ Supreme Court

ATTORNEYS AT LAW
50 PARK PLACE, 10TH FLOOR
NEWARK, NEW JERSEY 07102

PAUL W. BERGRIN
Certified Criminal
Attorney by the NJ
Supreme Court

(973) 242-3700
Fax (973) 242-3799

E-Mail pbergrin@bergrin-firm.com

Dated: 2-10-09

Money received from:

Total Retainer Amt: \$5000.

Name: M. Higgs.

Address: _____

Telephone No. _____

Relationship: _____

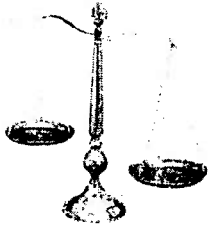
Re: State of New Jersey vs. Higgs

Address: _____

File No. _____

On today's date, this firm received the amount of \$ ~~4000~~ 4500.
cash check/credit card, as payment towards legal fees.

RB
Total paid \$4500.



LAW OFFICE OF PAUL W. BERGRIN

A PROFESSIONAL CORPORATION
Certified Criminal Trial Attorney by the NJ Supreme Court

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Dated: 2-9-09

Money received from: _____ Total Retainer Amt: _____

Name: *Michael Hegg*

Address: [REDACTED]

Telephone No. _____

Relationship: _____

Re: State of New Jersey vs. *Hegg*

Address: _____

File No. _____

On today's date, this firm received the amount of \$ 500.
cash/check/credit card, as payment towards legal fees.

Paul Bergin

1215 Liberty Ave.,
3rd Fl
Hillside, NJ 07205

RIGHT AWAY
BAIL BONDS "TRIPLE A SERVICE... RIGHT AWAY RESULTS!"

4178

Toll Free: 866-956-BAIL (2245)
Office: 908-965-0984
Fax: 908-965-0985

NAME: Victoria Higgs PHONE: _____
ADDRESS _____

DEFENDANT INFO		PRICE
FACILITY:		AMOUNT: <u>2,030</u>
BAIL AMOUNT:	<u>2,000</u>	FILING FEE:
DEFENDANT'S NAME:	<u>Michael Higgs</u>	MISC:
COMMENTS:		TOTAL: <u>2,030</u>
PAYMENT		AMOUNT PAID: <u>2,030</u>
<input checked="" type="checkbox"/> CASH	<input type="checkbox"/> MONEY ORDER	BALANCE DUE:
<input type="checkbox"/> CHECK	<input type="checkbox"/> CASHIER CK	THANK YOU!
<input type="checkbox"/> CREDIT CARD	<input type="checkbox"/> OTHER	
RECEIVED BY: <u>Shou Shen</u>		DATE: <u>7/1/09</u>

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED

UNION COUNTY COUNSEL
RECEIVED
JAN 14 2011
ADMINISTRATION BUILDING
ELIZABETH, NJ

1. Claimant:

DeLouisa, Vincent, Angelo
Last Name, First, Middle

11/15/61
Date of Birth

[REDACTED]
Street Address/Mailing Address

[REDACTED] [REDACTED]
City, State, Zip Code

[REDACTED]
Social Security No.

A

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name: Paul K. Caliendo, Esq./Gill & Chamas, LLC

Mailing Address: 655 Florida Grove Road, P.O. Box 760

Woodbridge, New Jersey 07095
City, State Zip Code

Relationship to Claimant: Attorney at Law (xx) or

Explain Relationship – Legal Representation

3. The occurrence or accident which gave rise to this claim:

A. On or about 6/10/10 not applicable
Date Time

B. Describe the location or place of the accident or occurrence

Summit, NJ 07902
Municipality

Overlook Hospital, 99 Beauvoir Ave
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If diagram will assist your explanation, please use the reverse side of this form.

Medical malpractice resulting from negligent and improper care
resulting decubitus ulcers

4. A. Claim for Damages (Check the appropriate block)

Personal Injury Property Damage

Other – Explain in detail _____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

See above No.3

B2. Do you claim permanent disability resulting from this injury?

Yes No

If yes, describe the injuries believed to be permanent.

See above No. 3

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility – Overlook Hospital

b. Address – 99 Beauvoir Avenue, Summit, NJ 07902-0220

c. Dates of treatment or services – To be supplied

d. Amount of charges to date – To be supplied

e. Amount paid or payable by other sources such as insurance – To be
be supplied.

a. Name of Hospital, Doctor or other Facility – Manor Care

b. Address – 1180 Route 22 West, Mountainside, NJ

c. Dates of treatment or services – To be supplied

d. Amount of charges to date – To be supplied

e. Amount paid or payable by other sources such as insurance – To be
be supplied.

B4. If you claim loss of wages or income as a result of the injury, state

<u>Union County Dept. of Corrections</u>	<u>15 Elizabethtown Plz, Elizabeth, NJ</u>
Name of Employer	Address of Employer
<u>Correction Officer</u>	<u>May of 1999</u>
Your Occupation	Date of Employment
<u>To be supplied</u>	<u>To be supplied</u>
Rate of Pay	Date of absence from work
<u>To be supplied</u>	

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you. – **To be supplied if applicable.**

To be supplied, if applicable.

6. If you claim property damage; - **Not applicable.**

A. Describe the property damage:

B. The present location and time when the property may be inspected:

Not applicable.

<u>LOCATION</u>	<u>DATE</u>	<u>TIME</u>
-----------------	-------------	-------------

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

Repaired by

When

Costs of Repair

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

Other than pain and suffering, disability, loss of enjoyment and loss income, to be supplied.

B. The amount of the claim

8. A. State the name and address of the agency or agencies that you claim caused your damage.

Overlook Hospital, 99 Beauvoir Avenue, Summit, NJ 07902-0220

B. State the names of employees whom you claim were at fault, including any information that will assist in identifying and locating them.

Unknown at this time.

9. State the negligence or wrongful acts of the agencies and agencies employees which caused your damages.

To be determined

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable. **To be supplied.**

<u>Name & Address of Ins. Co</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>
<u>Name & Address of Ins. Co</u>	<u>Policy Number</u>	<u>Benefits Paid or Payable</u>

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

() Yes (x) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expenses and other losses and expense claimed. None in Claimant's possession at this time.

B. Full copies of all appraisals and estimates of property damage claims by you. Not applicable.

C. Copies of all written reports of all expert witnesses and treating physicians. None in Claimant's possession at this time.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income. Not in Claimant's possession at this time.

E. Completed "Authorization for Release of Health Information: see attached form. See attached.

Gill & Chamas, LLC
Attorneys for Claimant

BY: 
PAUL K. CALIENDO, ESQ.

DATED: 



COUNTY OF UNION

Part C - GOVERNMENT RECORDS REQUEST RESPONSE

Requestor: Tina Reina - UCWA

Request Date: 1/19/11

- Document(s) provided: e-file pages, at a total cost of: no fee.
- Special Service Charge imposed - Reason: _____
- Document(s) have been inspected by the requestor on the date shown below: _____ documents, _____ total pages
- Document(s) not provided (see below)

Item 5 - Notice of Claims
Dec. 13, 2010 - Jan. 15, 2011, cost: _____

The document(s) you have requested that are checked below are NOT being provided because the document(s) are considered privileged or are otherwise exempt from public access, as provided by applicable law:

- Privileged or Protected Category**
- Advisory, Consultative or Deliberative material
 - Autopsy Photos / Video
 - Attorney-Client Privilege Information
 - Computer Security Information
 - Criminal Investigatory Records
 - Credit Card Numbers
 - Domestic Security (Sabotage or Terrorism)
 - Grievance Information with public employer
 - Drivers' License Numbers
 - Electronic Surveillance Materials
 - Emergency or Security Information or Procedures
 - Employee Sexual Harassment Complaints
 - Fingerprint Cards
 - Individual's Medical, Financial, or Tax records
 - Insurance Communications
 - Investigation in Progress
 - Labor Negotiation Information (strategy or positions)
 - Personnel or Pension Records
 - Photographs of Crime Scene
 - Proprietary Information
 - Reasonable Expectation of Privacy home addresses
 - Resumes of unsuccessful applicants
 - Safety of persons or the public
 - Security Measures and Surveillance Techniques
 - Social Security Numbers
 - Test Questions, Scoring Keys, or other Exam Data
 - Victim records
 - Record has been destroyed/not retained pursuant to:
 - Other

- Authority for Denial or Redaction**
- N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - Executive Order 21 (McGreevey)
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 2A:156A-19
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - Executive Order 9 (Hughes)
 - Executive Order 26 (McGreevey)
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-3.a
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-10
 - Executive Order 9 (Hughes)
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - Executive Order 26 (McGreevey)
 - Executive Order 69 (Whitman)
 - N.J.S.A. 47:1A-1.1, et seq.
 - N.J.S.A. 47:1A-1.1, et seq.
 - Executive Order 26 (McGreevey)
 - N.J.S.A. 47:1A-1.1; N.J.S.A. 2A:82-46b
 - Records Retention and Disposition Schedule

You have a right to appeal this decision that the documents requested are not accessible. You may take your appeal to the Government Records Council (GRC) or to the New Jersey Superior Court as provided by N.J.S.A. 47:1A-6 and 7. Please see the attached "Part D - Procedures to Challenge Denial of Access to Government Records" and GRC information.

Date: 1/28/11

[Signature]
County Official

ACKNOWLEDGMENT

I hereby acknowledge that I have received copies of, or have been permitted to view/inspect, the documents requested except for any documents specifically listed above on which a determination has been made that the documents could not be provided in accordance with applicable law. If any documents have not been provided, I have received information as to the procedures for an appeal of the determination.

Date: _____

Requestor's Signature _____