American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

(Applicant)

- and -

Geico Insurance Company
(Respondent)

AAA Case No.	17-23-1289-4411
Applicant's File No.	NA
Insurer's Claim File No.	0421852050101067
NAIC No.	

ARBITRATION AWARD

I, Michelle Murphy-Louden, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD:**

Injured Person(s) hereinafter referred to as: Applicant

1. Hearing(s) held on 07/27/2023, 12/14/2023, 07/11/2024
   Declared closed by the arbitrator on 08/27/2024

   Greg Vinal, Esq. from Vinal & Vinal, P.C. participated virtually for the Applicant

   Spence Packer, Esq. from Geico Insurance Company participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **$13,300.00**, was NOT AMENDED at the oral hearing.
   Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

   The 35 year old male Applicant was reportedly involved in a motor vehicle accident on October 15, 2018, as a driver.

   The issue presented is whether Applicant is entitled to reimbursement for chiropractic treatment rendered from October 15, 2018, to June 10, 2022, as the result of the October 15, 2018, motor vehicle accident.

Respondent contended that it previously reimbursed the treating chiropractor for dates of service October 19, 2018, to April 9, 2019.

Respondent contended that it never received claims for the following dates of service prior to Applicant's filing of his request for arbitration:

4/17/19 - 4/27/19

6/4/19 - 6/24/19

4/2/22 - 6/10/22

Respondent denied reimbursement for the following dates of service based upon a March 21, 2019, chiropractic independent medical examination (IME) performed by Craig Horner, D.C.:

5/2/19 - 5/31/19

7/1/19 - 3/16/22

This Award is based upon a review of all of the documents contained within the ADR Center electronic case file as of the date of the Award, as well as upon any oral arguments of the parties and any testimony given during the hearing.

4. Findings, Conclusions, and Basis Therefor

Applicant seeks herein reimbursement for chiropractic treatment rendered by Paul Gillezeau, D.C., Gillezeau Chiropractic.

Respondent submitted into evidence a copy of the Assignment of Benefits Applicant executed in favor of Gillezeau Chiropractic on October 19, 2018.

Applicant submitted into evidence a copy of a Statement of Distribution and a check issued from the escrow account of his personal injury attorney payable to Gillezeau

Chiropractic on April 27, 2022. According to the Statement, Applicant authorized his personal injury attorney to pay a lien asserted by Gillezeau Chiropractic in the amount that is in dispute in this matter from the proceeds of his personal injury action.

In Allstate Ins. Co. v. Kapeleris, 183 A.D.3d 626 (App. Div., 2nd Dept., 2020) the court held that a No-Fault Assignment of Benefits, though valid when made, is rendered ineffectual once a medical provider directly bills the injured-assignor for services that were denied by an insurer for lack of medical necessity, and that an injured-assignor who pays the bills maintains standing to pursue her claims for No-Fault benefits against the insurer.

Therefore, based upon the ruling in Kapeleris, I find that Applicant has established standing to pursue the within arbitration by virtue of his payment of Gillezeau Chiropractic's lien, and as such this case will proceed on the merits.

DATES OF SERVICE 10/15/18 - 4/9/19

With respect to date of service October 15, 2018, the evidence submitted shows that Applicant's initial office visit at Gillezeau Chiropractic took place on October 19, 2018. There is no evidence in the record supporting Applicant's claim of treatment being provided on October 15, 2018, four days before the initial office visit. Therefore, Applicant's claim for this date of service is denied.

With respect to dates of service October 19, 2018, to April 9, 2019, Respondent submitted proof of payment showing that it paid Gillezeau Chiropractic in the full amount charged for this time period. Therefore, Applicant's claim for these dates of service is also denied.

DATES OF SERVICE

4/19/19 - 4/27/19

6/4/19 - 6/24/19

4/2/22 - 6/10/22

In support of its contention that it never received claims from Gillezeau Chiropractic for the above-listed dates of service prior to Applicant's filing of his request for arbitration, Respondent submitted the August 1, 2024, Affirmation of Jason Forman, Claims Supervisor, in which he affirmed in relevant part:

> 3. Based upon my training, experience, and daily job responsibilities, I am qualified and authorized to attest to the particulars noted in no-fault claim related documents and records, including those kept in GEICO's computer system, and GEICO's Claims' standard operating procedures relating to the handling of no-fault claims.
>
> 4. My responsibilities in GEICO Claims include access to and review of no-fault claim related documents and records that are made in the regular course of business by GEICO Claims, and it is in the regular course of GEICO Claims' business to make such documents and records.
>
> 5. My responsibilities also include access to and review of no-fault claim related documents and records that are received in the regular course of business by GEICO Claims, including records received from policy holders, insured persons, claimants, medical providers, assignees, and attorneys, etc. These documents and records also include payments made, and offsets withheld, for PIP benefits under GEICO policies.
>
> 12. In the regular course of business, as a standard practice of my employment and my responsibilities, I conducted a thorough review of GEICO Claims' records relating to this dispute.
>
> 13. Based upon the above, I hereby attest to the following facts relating to the issues in dispute in the instant case regarding claim number 0421852050101067:
>
> GEICO did not receive billing from Gillezeau Chiropractic P.C. for treatment rendered to

[Applicant] for the following alleged dates of service:

4/17/2019

4/20/2019

4/23/2019

4/27/2019

6/4/2019

6/8/2019

6/11/2019

6/13/2019

6/17/2019

6/19/2019

6/21/2019

6/24/2019

4/2/2022

4/13/2022

4/22/2022

4/30/2022

5/7/2022

5/19/2022

6/10/2022

Applicant argued that following Respondent's issuance of the general denial on April 3, 2019, based upon Dr. Horner's IME, which became effective on April 10, 2019, he was excused from further compliance with the condition precedent that he submit proof of claim within 45 days pursuant to the ruling in State Farm Ins. Co. v. Domotor, 266 A.D.2d 219 (App. Div., 2nd Dept, 1999). Respondent argued that the ruling in Domotor did not apply because it was rendered three years before the effective date of the current No-Fault Regulation on April 5, 2002, which requires that proof of claim for medical expenses be submitted within 45 days.

I have, up to this point, consistently followed the ruling in Domotor. However, upon further analysis and evaluation, I am no longer inclined to do so for the reason that follows:

The ruling in Domotor has been followed by multiple courts since the 2002 inception of the current No-Fault Regulation (*see e.g.* Medalliance Med. Health Servs. v. Travelers Prop. Cas. Ins. Co., 72 Misc. 3d 1213(A), Dist. Ct., 4th Dist., Suffolk Co., 2021; Country-Wide Ins. Co. v. Yao Jian Ping, 83 Misc. 3d 182, N.Y.C. Civ. Ct., N.Y. Co., 2024; Matter of Ny Med. Health P.C. v. New York City Tr. Auth., 24 Misc. 3d 1219(A), N.Y.C. Civ. Ct., Kings Co., 2009). However, with the exception of two cases which will be discussed below, the rulings in the above-cited cases as well as other cases reviewed by this arbitrator did not address the September 2, 2004, Opinion of the Office of General Counsel of the N.Y.S. Insurance Department (now the Department of Financial Services), Opinion No. 04-09-03, which states in relevant part:

Question Presented

After a No-Fault insurer has denied all future benefits for continued treatment by a health provider of an eligible injured person based upon the negative findings of an insurer's medical examination of that person, must the insurer continue to issue denials for claims for continued treatment which are submitted subsequent to the issuance of the denial for all future benefits?

Conclusion

Yes. Pursuant to Section 5106(a) of the Insurance Law and Sections 65-3.8(a)(1) and 65-3.8(c) of Department No-Fault Regulation 68, whenever a No-Fault provider submits a claim for reimbursement to an insurer, the insurer must pay or deny the claim within 30 calendar days after receipt of proof of claim. There is no provision in either the No-Fault statute or regulation which relieves an insurer of the obligation to pay or issue a denial on all claims for benefits submitted. *Neither does the statute or regulation relieve an applicant for benefits of their responsibility to submit claims in order to be eligible for the payment of benefits, even after receiving a denial of all future benefits* [emphasis added].

Analysis

…N.Y. Code R. & Regs. tit. 11 § 65-3.8(a)(1) (2002) (Department Regulation 68), states that in the section entitled "Payment or denial of claim (30 day rule)", it is stated that "No-fault benefits are overdue if not paid within thirty calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested pursuant to section 65-3.5 of this subpart". Section 65-3.8(c) simply states "Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part."

With respect to requesting reimbursement for health services rendered (i.e. "loss"), under the prescribed New York No-Fault endorsement found in N.Y. Code R. & Regs. tit. 11 § 65-1.1(d) (2002), under the Proof of Claim provision for medical claims, it states that "In the case of a claim for health service expenses, the eligible injured person or that person's assignee or representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of injuries and treatment received and contemplated, as soon as reasonably practicable but, in no event later than 45 days after the date services are rendered".

> Accordingly, *the obligation of an applicant to submit timely claims to be eligible for reimbursement remains continuous, irrespective of whether an insurer has denied a claim and indicated that all future claims will be denied* [emphasis added]. Once an insurer is in receipt of a subsequent claim, pursuant to Section 65-3.8(c), the insurer must issue a timely 30 day denial. Even when a claim is submitted after the insurer indicated it would not pay future benefits, based upon the negative findings of the insurer's medical examination, the insurer's obligation to pay or deny that claim within 30 days remains.
>
> *…Accordingly, an applicant for benefits must also continue to submit their claims on a timely basis in order to protect their rights to reimbursement, in the event that it is ultimately established that the services rendered were medically necessary despite a negative IME report* [emphasis added].

In Dugo v Allstate Ins. Co., 26 Misc. 3d 1215(A) (N.Y.C. Civ. Ct., Richmond Co., 2010), the court held that the Insurance Department's opinion that the obligation of an applicant to submit timely claims to be eligible for reimbursement remained continuous irrespective of whether the insurer had issued a denial was merely dicta, and thus the court did not engage in a thorough analysis of the issue.

In Greater Forest Hills Physical Therapy, PC v. State Farm Mut. Auto. Ins. Co., 5 N.Y.S.3d 328 (Dist. Ct., 1st Dist. Nassau Co.), the one case found by this arbitrator that did discuss the Insurance Department's Opinion, the defendant argued that the plaintiff's action was barred because it never submitted the claims for the treatment in dispute. The plaintiff argued that once the defendant had denied further No-Fault benefits based upon an IME, it was no longer obligated to submit proof of claim forms to the defendant pursuant to the ruling in Domotor. In response, the defendant cited to Insurance Department Opinion No. 04-09-03 in support of its argument. Following its review of the Insurance Department's Opinion, the court held:

> Although this court is somewhat sympathetic to the position of defendant presented herein, this court is constrained to follow the Second Department that plaintiffs are not obligated to timely submit claims for no-fault benefits once an insurance carrier denies coverage.
>
> This court urges defendant to appeal this decision to have the Second Department review this matter in light of the position of the State Insurance Department.

I found no evidence indicating that the defendant in the above case appealed the ruling.

Unlike courts, arbitrators are not bound by substantive law (*see* Chin v. State Farm Ins. Co., 73 A.D.3d 918, App. Div., 2nd Dept., 2010) or judicial precedent (*see* Peerless Ins. Co. v. Davis, 2017 N.Y. Misc. LEXIS 8406, Sup. Ct., Dutchess Co., 2017).

In State Farm Mut. Auto. Ins. Co. v. Mallela, 4 N.Y.3d 313 (2005), the Court of Appeals held that the "Superintendent [of Insurance's] interpretation [of the Regulation], if not irrational or unreasonable, will be upheld in deference to his special competence and expertise with respect to the insurance industry, unless it runs counter to the clear wording of a statutory provision".

I do not find the Insurance Department's Opinion that an applicant continues to bear an obligation to timely submit claims for No-Fault benefits in order to be eligible for reimbursement after the insurer has denied all future benefits based upon an IME to run counter to the Proof of Claim provisions of 11 N.Y.C.R.R. §65-1.1. I am not aware of any case wherein a court has held that the Insurance Department's interpretation of the Proof of Claim provisions as expressed in its Opinion No. 04-09-03 was irrational or unreasonable and thus not entitled to deference.

Based upon the foregoing, I find in this matter that Applicant bears the burden of establishing prima facie that the claims for the above specified dates of service were submitted to Respondent prior to the filing of his request for arbitration and are now

overdue. However, because Applicant is the patient and not the medical provider and thus does not have knowledge of whether the claims were submitted to Respondent by Dr. Gillezeau, I am dismissing Applicant's claim for the above specified dates of service without prejudice so that he may determine if Dr. Gillezeau submitted these claims to Respondent for payment.

As to the remaining dates of service at issue, I find as follows:

Applicant, then 35 years old, was reportedly involved in a motor vehicle accident on October 15, 2018, when the vehicle in which he was the restrained driver was struck head-on by an oncoming vehicle while traveling approximately 50-60 mph.

According to the records, on October 19, 2018, Applicant presented for initial chiropractic evaluation with Paul Gillezeau, D.C., reportedly complaining of 8/10 thoracic pain aggravated by bending and sitting and 8/10 lumbar pain aggravated by bending, twisting, and sitting. Following examination, Dr. Gillezeau diagnosed Applicant with thoracic and lumbosacral sprains and recommended treatment 2 times per week.

On October 24, 2018, Applicant underwent a lumbar MRI which was with the impression of slight straightening of the lordosis, T11-T12 left paracentral disc herniation which partially effaces the left anterior subarachnoid space and L5-S1 central disc herniation which encroaches upon the anterior epidural fat.

Submitted by the parties are Dr. Gillezeau's treatment notes for 2019-2021 which document continued complaints of thoracic and lumbar pain variably rated 3-7/10 and palpable thoracic and lumbar pain and tension.

IME

On March 12, 2019, Applicant underwent a chiropractic IME performed by Craig Horner, D.C., who previously examined Applicant on February 5, 2019, at which time he was reportedly complaining of neck, mid-back, lower back, and bilateral knee pain.

The findings of Dr. Horner's examination are set forth in his report as follows:

EXAMINATION OF THE CERVICAL SPINE: Examination of the cervical spine revealed no spasms. There was no tenderness to palpation. There was no evidence of disturbed alignment. Neurological examination of the upper extremities demonstrated normal strength of 5/5 in all major muscle groups. Sensory responses were intact throughout the upper extremities. Deep tendon reflexes of the biceps, triceps and brachioradialis were +2 and equal bilaterally. Cervical Compression test was negative. Cervical distraction test was negative.

CERVICAL SPINE

RANGE OF MOTION	NORMAL	CLAIMANT
FLEXION	50°	40°
EXTENSION	60°	20°
RIGHT ROTATION	80°	45°
LEFT ROTATION	80°	45°
RT. LATERAL FLEXION	45°	20°
LT. LATERAL FLEXION	45°	15°

There was suboptimal effort during the examination.

EXAMINATION OF THE THORACIC SPINE: Examination of the thoracic spine revealed no paraspinal spasms. There was minimal paraspinal tenderness. There was no evidence of disturbed alignment.

EXAMINATION OF THE LUMBAR SPINE: Examination of the lumbar spine revealed no paraspinal spasms. There was no paraspinal tenderness upon palpation. There was no evidence of disturbed alignment. Neurological examination of the lower extremities demonstrated normal strength of 5/5 in all major muscle groups. Sensory responses were intact throughout the lower extremities. Patellar and Achilles reflexes were +2 and equal bilaterally. Seated straight leg raising test was negative. Kemps test was negative.

LUMBAR SPINE

RANGE OF MOTION	NORMAL	CLAIMANT
FLEXION	60°	40°
EXTENSION	25°	15°
RT LATERAL BENDING	25°	15°
LEFT LATERAL BENDING	25°	10°

There was suboptimal effort during the examination.

Dr. Horner diagnosed Applicant with resolved cervical spine, thoracic spine, and lumbar spine sprains/strains and opined in relevant part:

> Decreased range of motion on examination of the cervical spine and lumbar spine was dependent on the claimant's effort.
>
> The claimant demonstrated poor effort during testing. The chiropractic examination demonstrated no objective positive findings upon examination. No further chiropractic treatment is indicated. The claimant has reached an end result in chiropractic treatment.

Based upon Dr. Horner's opinion, Respondent issued a general denial to Applicant on April 3, 2019, denying in part further chiropractic treatment effective April 10, 2019.

APPLICANT'S TESTIMONY

Applicant appeared virtually for the July 11, 2024, hearing in this matter and testified under oath as follows:

Direct Examination:

During the accident he hurt his lower back and his spine in between the shoulders.

He has a "bunch" of herniated discs, eleven in total.

He treated at Gillezeau Chiropractic.

He remembers attending IME's with Dr. Horner. He thinks there were at least three IME's.

He does not know if Respondent was paying Dr. Gillezeau.

He is still treating with Dr. Gillezeau.

He had filed a personal injury action through the office of John Fromen. Money from the settlement of this action was paid to Dr. Gillezeau, about $14,000.00.

If he did not go to Dr. Gillezeau every 2-3 days he would have "violent pains" in his back.

He could not function without chiropractic treatment.

His pain did improve over time. His pain level did decrease.

He talked to Dr. Sudabby about surgery. Dr. Sudabby said that he had a collapsing lumbar disc. He never had surgery because he is "just holding out".

He is able to get by with the pain in his back with chiropractic treatment.

Cross-Examination:

It took a "couple few months" for the chiropractic treatment benefit to start.

ANALYSIS

Once an applicant has established a prima facie case of entitlement to No-Fault benefits, the burden then shifts to the insurer to prove that the disputed services were not medically necessary. To meet this burden, the insurer's denial(s) of the applicant's claim(s) must be based on a peer review, IME report, or other competent medical evidence that sets forth a clear factual basis and a medical rationale for the denial(s). Amaze Medical Supply, Inc. v. Eagle Ins. Co., 2 Misc. 3d 128A (App. Term, 2nd Dept., 2003); Tahir v. Progressive Cas. Ins. Co., 12 Misc. 3d 657 (N.Y.C. Civ. Ct., N.Y. Co., 2006); Healing Hands Chiropractic, P.C. v. Nationwide Assurance Co., 5 Misc. 3d 975 (N.Y.C. Civ. Ct., N.Y. Co., 2004); Millennium Radiology, P.C. v. New York Cent. Mut. , 23 Misc. 3d 1121(A) (N.Y.C. Civ. Ct., Richmond Co., 2009); Beal-Medea Prods., Inc. v GEICO Gen. Ins. Co., 27 Misc. 3d 1218(A) (N.Y.C. Civ. Ct., Kings Co., 2010); All Boro Psychological Servs., P.C. v GEICO Gen. Ins. Co., 34 Misc. 3d 1219(A) (N.Y.C. Civ. Ct., Kings Co., 2012).

I find that Dr. Horner's IME fails to set forth a clear factual basis and a medical rationale for Respondent's denial of Applicant's claim for the treatment in dispute herein and as such I find that Respondent has failed to establish a lack of medical necessity for same.

Dr. Horner stated that Applicant exhibited suboptimal effort during the examination, but did not indicate the performance of Waddell testing or otherwise explain the basis for his opinion. Therefore, Respondent's denial cannot be upheld.

AMOUNT AWARDED

For the time periods May 2, 2019, to May 31, 2019, and July 1, 2019, to September 30, 2020, Applicant is entitled to reimbursement for 95 dates of service in the allowable Fee Schedule amount of $35.52 each for a total award amount of $3,374.40.

For the time period October 5, 2020, to March 16, 2022, Applicant is entitled to reimbursement for 82 dates of service in the amount of $54.73 each as paid to Dr. Gillezeau as this amount is less than the allowable Fee Schedule amount of $66.60 each for a total award amount of $4,487.86.

With respect to the amount of interest awarded Applicant herein, same is to be calculated in accordance with 11 N.Y.C.R.R. §65-3.9(c) as Applicant did not request arbitration within 30 days of receipt of the denial of claim form. The commencement date of the interest awarded shall be, per advisement of the Department of Financial Services, the date on which Applicant's request for arbitration was received by AAA. According to AAA's electronic case file Applicant's request for arbitration was received via e-mail by AAA on March 6, 2023. Therefore, Respondent shall pay Applicant interest commencing March 6, 2023, to the date of payment of this Award.

ACCORDINGLY:

1. APPLICANT IS AWARDED THE AMOUNT OF $7,862.26 FOR DATES OF SERVICE 5/2/19 - 5/31/19 AND 7/1/19 - 3/16/22 TOGETHER WITH INTEREST, ATTORNEY'S FEE, AND FILING FEE AS SET FORTH BELOW.

2. APPLICANT'S CLAIM FOR DATES OF SERVICE 4/17/19 - 4/27/19, 6/4/19 - 6/24/19, AND 4/2/22 - 6/10/22 IS DISMISSED WITHOUT PREJUDICE.

THE REMAINDER OF APPLICANT'S CLAIM IS DENIED IN ITS ENTIRETY.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
   - ☐ The policy was not in force on the date of the accident
   - ☐ The applicant was excluded under policy conditions or exclusions
   - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
   - ☐ The applicant was not an "eligible injured person"
   - ☐ The conditions for MVAIC eligibility were not met
   - ☐ The injured person was not a "qualified person" (under the MVAIC)
   - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
   - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		**From/To**	**Claim Amount**	**Status**
		10/15/18 - 06/10/22	**$13,300.00**	**Awarded: $7,862.26**
Total			**$13,300.00**	**Awarded: $7,862.26**

B. The insurer shall also compute and pay the applicant interest set forth below. 03/06/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Pursuant to 11 N.Y.C.R.R. §65-3.9(a), the insurer shall calculate interest at the rate of two percent per month, simple, calculated on a pro rata basis using a 30-day month.

Pursuant to 11 N.Y.C.R.R. §65-3.9(c), if an applicant does not request arbitration or institute a lawsuit within 30 days after receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken.

Since Applicant herein did not request arbitration within 30 days of receipt of the denial of claim form, Respondent shall pay interest from the date the arbitration was commenced as set forth above to the date of payment of the Award in accordance with 11 N.Y.C.R.R. §65-3.9(c).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

The insurer shall pay the Applicant an attorney's fee in accordance with 11 N.Y.C.R.R. §65-4.6(d).

D. The respondent shall also pay the applicant forty dollars ($40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY
SS :
County of Saratoga

I, Michelle Murphy-Louden, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

09/03/2024
(Dated)

Michelle Murphy-Louden

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
f6ad07345da75a359edabc55492cb4f3

Electronically Signed

Your name: Michelle Murphy-Louden
Signed on: 09/03/2024