Approved April 25, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Elwaine F. Pomeroy at
Chairperson

10:00 a.m./~~p.m.~~ on March 19, 1984 in room 514-S of the Capitol.

~~All~~ members ~~were~~ present ~~except~~ were: Senators Pomeroy, Winter, Burke, Feleciano, Steineger and Werts.

Committee staff present: Mary Torrence, Office of Revisor of Statutes
Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department

Conferees appearing before the committee:

Representative Robert Vancrum
Representative Elizabeth Baker
Senator Bill Morris
Kathleen Sebelius, Kansas Trial Lawyers Association
Jerry Palmer, Kansas Trial Lawyers Association
John Brookens, Kansas Bar Association
L. M. Cornish, Kansas Association of Property & Casualty Insurance Companies
Al Callaway, Capital Recovery Company
Philip Skow, Capital Recovery Company
Bud Grant, Kansas Chamber of Commerce and Industry

House Bill 2932 - Wrongful death actions; maximum damages; evidence of spouse's remarriage.

Representative Robert Vancrum, the prime sponsor of the bill, testified this bill will increase the $25,000 limit of nonpecuniary wrongful death damages to $100,000. A copy of his testimony is attached (See Attachment No. 1).

Representative Elizabeth Baker, one of the sponsors of the bill, testified this bill represents some of this legislature's dedication to the concept that human life is measured in terms other than pecuniary loss. A copy of her remarks is attached (See Attachment No. 2).

Senate Bill 847 - Consumer protection from automatic telephone dialing-announcing devices.

Senator Bill Morris explained this bill was introduced because of the problems of interference of persons being called by a recorded robot-type device on the telephone. He said this machine is a real annoyance, and with your help, we can do something about it.

House Bill 2932 - Wrongful death actions; maximum damages; evidence of spouse's remarriage.

Kathleen Sebelius appeared in support of the bill and stated there are persons throughout the state who are directly affected by this bill. A copy of her handout is attached (See Attachment No. 3).

Jerry Palmer testified the trial lawyers are in support of the bill in its present form. He stated the organization is opposed to any limitation on wrongful death area. He said there should be no lid or raise it to $100,000. He referred to a current case in Topeka that is a practical example of what happens. The insurance company offered $20,000 to the family of a boy whose life was lost in the accident.

John Brookens testified the bar association does support the bill as it is now written. However, a jury should not be shielded from truth and fact, and therefore, the Kansas Bar Association believes evidence of remarriage should be admissible in evidence.

Bud Cornish testified this bill is one of three bills that impact on automobile insurance premium rates. Although liability insurance is compulsory, so is insurance premium

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:00 a.m./~~p.m.~~ on March 19, 1984.

House Bill 2932 continued

important to the people of Kansas. In this instance the $25,000 has been on the books for sometime. Mr. Cornish stated his groups oppose an increase. He suggested a lessor figure of $50,000 which would double the amount as set out now.

House Bill 2598 - Sale of tobacco products to persons under 18 unlawful.

Representative Elizabeth Baker, the sponsor of the bill, urged the committee to report the bill favorably in recognition of the inherent dangers in all tobacco products. A copy of her testimony along with a copy of clinical findings of the University of Colorado School of Dentistry are attached (See Attachments 4 & 5). She also handed out pictures showing the result of chewing or smoking tobacco for committee members to view. The chairman pointed out the committee will probably amend the bill to correct an unintended side effect. A committee member inquired, how is the legislature going to enforce this? Representative Baker replied, the legislature is making a statement. The people feel with this kind of law, this can be controlled, especially in small towns. Committee discussion followed.

Senate Bill 846 - Limitations on agreements for recovery of unclaimed property.

Al Callaway testified there is a need for the bill, but would suggest a few changes. A copy of his testimony with other material are attached (See Attachment No. 6). In response to a question, Mr. Callaway stated he had been in business for about two months. The chairman inquired, are you concerned with the 24 month waiting period? Mr. Callaway replied, it validates any fees they contract to make; so far no one has renegged on the contract.

Philip Skow testified he is familiar with unclaimed property laws of other states and feels two years is too long. He doesn't know of any other state that comes close to two years. The 10% law would definitely put them out of business; most of their claims are small claims. A committee member inquired, should we set up a graduated scale on these fees? Mr. Sknow replied, that could be done, but urged the committee to remember we are speaking of a small sum basically.

The chairman asked Senator Feleciano to contact the treasurer's office to inquire if they wish to appear on Senate Bill 846.

Senate Bill 847 - Consumer protection from automatic telephone dialing-announcing devices.

Bud Grant testified this bill originated last week, and his organization is not opposed to the bill. There seems to be no evidence that the general public opposes the use of the telephone for sales purposes. He said he sees this as benefiting people. This service is not new; some businesses call their customers when their order is in or their catalog is in. He suggested an amendment to the bill on page 1, line 31, to strike "or"; in line 32, after "use", insert "or when the recipient's consent is obtained on the telephone at the beginning of the solicitation".

House Bill 2932 - Wrongful death actions; maximum damages; evidence of spouse's remarriage.

Senator Steineger moved to report the bill favorably; Senator Burke seconded the motion, and the motion carried.

House Bill 2598 - Sale of tobacco products to persons under 18 unlawful.

Committee discussion was held on the bill. No action was taken.

Senate Bill 847 - Consumer protection from automatic telephone dialing-announcing devices.

Senator Burke moved to amend the bill on page 1, line 31, by striking "or"; in line 32, after "use", insert "or when the recipient's consent is obtained on the telephone at the beginning of the solicitation". Senator Feleciano seconded the motion. Senator Feleciano withdrew his second. Following committee discussion, Senator Winter seconded Senator's Burke's motion, and the motion carried. Senator Winter moved to report the bill favorably as amended; Senator Burke seconded the motion, and the motion carried.

The meeting adjourned.

3-19-84

GUESTS

SENATE JUDICIARY COMMITTEE

NAME	ADDRESS	ORGANIZATION
Rep. Elizabeth Baker		
Phil Wilbes		Dept. of Revenue
John Spurgeon		Budget
Cheryl Armstrong		Girl Scouts
Katie McNaughton		Girl Scouts
Melissa DeNoon		Girl Scouts
Tiffany Poulton		Girl Scouts
Rachelle Sharbutt		Girl Scouts
Al Callaway		Capitol Recovery Co.
Ed Schaub	Topeka	S.W.B.T.
Mark Bennett	Topeka	Assurance Assoc
Bud Grant	Topeka	KCCI
Don Conyers	"	Ks Assoc of P/C Ins Cos
Jerry Palmer	Topeka	KTLA
Sen. Bill Morris		Senate
W. W. Scott	Mission	State Farm Ins
Jerry Davis	McPherson	Farmers Alliance Mut. Ins. Co.
Homer Cowan	Ft Scott	The Western Ins Co's
Larry Magill	Topeka	Indep. Ins. Agents of Ks.
B Massey	"	Press
Wilbur Leonard	"	Ks. Telephone Assn
PHILIP SISON	CARBONDALE	CAPITAL RECOVERY CO.
M. Hawver	~~Eff~~ Topeka	Capitol Journal

3-19-84
Attach. #1

BOB VANCRUM
REPRESENTATIVE, TWENTY-NINTH DISTRICT
OVERLAND PARK
9004 W 104TH STREET
OVERLAND PARK, KANSAS 66212
(913) 341-2609
STATE CAPITOL, ROOM 115-S
TOPEKA, KANSAS 66612
(913) 296-7655

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
VICE-CHAIRMAN: FEDERAL AND STATE AFFAIRS
MEMBER: ASSESSMENT AND TAXATION
JUDICIARY

TESTIMONY OF REPRESENTATIVE ROBERT J. VANCRUM
SENATE JUDICIARY COMMITTEE
MARCH 19, 1984

HB 2932 - WRONGFUL DEATH DAMAGES

Thank you for this opportunity to appear before you with regard to HB 2932. This bill will increase the $25,000 limit of nonpecuniary wrongful death damages to $100,000.

Those of you who were on the committee last year remember HB 2061, which increased the limit to $100,000, and was passed out of this committee favorably last year. I have introduced a new bill this year because several parties have suggested that if minor changes were made in the bill they could support it. Section 2 has been added to the bill to permit evidence of remarriage of the spouse to be admissable so as to allow the defendant to introduce evidence which might give some indication of the extent of the nonpecuniary loss of the spouse. It is my understanding that the Kansas Bar Association Policy Committee wishes to have this added for the benefit of the insurance bar to offset the effect of increasing the limit.

I have also added Section 1b, which provides that the court will not instruct the jury as to the monetary limitation. The purpose of this section is to meet the argument that will be made that any limit which is set becomes a floor rather than a

Atch. 1

ceiling. Of course, I would argue that any time a limit is set too low it will naturally become a floor in that juries tend to be fair and award a reasonable amount of damages. Nevertheless, in the spirit of compromise I have included these two changes in the bill.

Since there are some new people on the committee this year, I find it necessary to say a few words concerning the need for the bill. In the first place, although under present Kansas law there is currently no limit on pecuniary damages (loss of wages, medical and other out-of-pocket damages), Kansas has had for several years a $25,000 lid on all other damages including punitive damages, and damages for pain and suffering and loss of the societal value of the individual to his or her family members. It may surprise you to find out that at least 21 states have no limit whatsoever on such damages and an additional 23 states no ceiling on damages other than punitive damages.

This ill-conceived lid leads to some really serious miscarriages of justice. Let me give one brief example. Let's assume for a moment that five people are standing under a skywalk in a hotel in Kansas which collapses and all five are killed. It is later determined that the collapse was caused by admitted negligence on the part of the construction company. Of the five people, one is a high-salaried working father, one is a child genius who is just about to graduate from high school, two are an older retired couple, and the last is a homemaker whose children are raised. Of these individuals, the family of the

first would be able to recover hundreds of thousands of dollars and possibly millions. But in Kansas, the other four because of this statute are treated as if their lives are worth only $25,000. The negligence in all five cases is exactly the same, but we are limiting the recovery in the latter four cases because of two things: (1) Apparently a large number of people at one time thought that the other four simply were not worth as much as the working father. (2) The insurance companies have steadfastly maintained, for the most part in the face of overwhelming evidence that if the lid is increased insurance premiums will rise dramatically. The facts simply do not support that analysis. In states that have removed the lid, premiums have not risen dramatically, and in fact most rates on casualty policies are set nationwide, which means the company is charging the same premium to Kansas policyholders as in other states and therefore simply making a larger profit. I have no problem with their profits, except that in this case they are earned at the expense of the number of families who have been treated very unjustly.

Since there are many other conferees, I will stop at this point and ask if you have any questions.

3-19-8
Attach. # 2

TO: Senate Judiciary Committee
FROM: Representative Elizabeth Baker
RE: HB 2932
OBJECTIVE: To prevail upon the committee to pass favorably the amendment to KSA 60-1903 and 60-1904 repealing the existing sections.

HB 2932 represents some of this legislature's dedication to the concept that human life is measured in terms other than pecuniary loss. It is a policy announcement by the legislature that reflects the concensus of opinion of Kansans concerning the appropriate value placed on love, affection companionship and counsel. The existing law is an appalling commentary on the notion of what is adequate compensation for these kinds of losses.

As present this law discriminates against the heirs or relatives of nonwage earners , i.e., children, housewives, the retired and those without earning capacity. While HB 2932 does not tatally eliminate the discriminatory impact of the law, it does represent a responsible reform. I urge you to recommend HB 2932 favorable for passage.

Atch. 2

3-19-94
K.S.
Attach. #3

WRONGFUL DEATH

H.B. 2932: Raises lid on non-pecuniary damages (pain and suffering, loss of consortium, loss of affection, guidance, companionship) from $25,000 to $100,000. As originally drafted, bill raised lid and introduces evidence of remarriage. The evidence section was struck by the Kansas House, and the bill passed the House 116-8.

Kansas law was last changed in 1975 when a total lid of $50,000 was removed and divided. There are now no limits on pecuniary loss (wages, medical bills), but a lid was placed on non-pecuniary losses. Kansas is one of only six states in the country with any limitation on wrongful death cases.

DEFENSE RESEARCH INSTITUTE: 1980

Study on Wrongful Death Laws

"Compensatory" covers pecuniary and non-pecuniary damages.

44 States: No Ceiling on Compensatory Damages -- those with * allow Punitive Damages.

Arizona*, Arkansas*, California, Connecticut, Delaware, District of Columbia*, Florida*, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky*, Louisiana, Maryland, Massachusetts*, Michigan, Minnesota, Mississippi*, Missouri*, Montana*, Nebraska, Nevada*, New Hampshire, New Jersey, New Mexico*, New York, North Dakota, Ohio, Oklahoma*, Oregon*, Pennsylvania*, Rhode Island*, South Carolina*, South Dakota, Tennessee*, Texas*, Utah, Vermont*, Virginia, Washington, West Virginia*, Wyoming*.

Other:

Kansas: $25,000 non-pecuniary lid - no punitive.
Maine: $10,000 non-pecuniary lid - no punitive.
Colorado: $45,000 total lid - no punitive.
Wisconsin: $10,000 non-pecuniary lid - no punitive.
Alaska: Only allows punitive damages.
North Carolina: Lid of $500.

Cases particularly affected include retired persons, children, non wage-earning spouses.

Att. 3

3-19-84
Attach. # 4

TO: Senate Judiciary Committee
FROM: Representative Elizabeth Baker
RE: House Bill 2598
OBJECTIVE: To prevail upon the committee to pass favorably the amendment to KSA 79-3386 in recognition of the inherent dangers in all tobacco products.

Last summer I received a call from an irate mother in my district who was attempting to influence positively her son's attitudes towards smokeless tobacco consumption. She had confronted him with what she believed was overwhelming evidence to support her position concerning the damage it would do to his health. His response wastypical of many teen-agers in that he felt if it wasn't illegal, it wasn't harmful. He was aware of the fact that the purchase and sale of cigarettes to minors was prohibited, but believed there were no health problems associated with the use of smokeless tobacco and that was the reason there were no laws governing it.

The Legislature recognizes the importance of protecting our youth from physically and mentally damaging influences, e.g. legislation governing drinking ages, cigarette sales to minors, etc. Moreover, the Legislature has not confronted this issue in the past for two fundamental reasons:

1. the negligible number of minors who used smokeless tobacco,

2. the lack of information as to the hazards of smokeless tobacco.

In reviewing the first reason, it must be noted that the number of teen-age and even elementary children that are involved in tobacco consumption are rapidly increasing. This increasing consumption is primarily in the area of smokeless tobacco and can probably be directly attributable to young people's attempts to emulate popular sports figures that they view with regularity "chewing and spitting" on television. It is a socially accepted habit that has permeated the behavioral patterns of our youth.

Atch. 4

In consideration of the second reason, the available evidence indicates that the use of smokeless tobacco has increased to such an extent that some form of rational regulation is required. The Kansas Dental Society was contacted and they provided the following information: The clinical findings of the University of Colorado School of Dentistry, "Oral Tissue Alterations Associated with Teenage Use of Smokeless Tobacco". This extensive report indicates conclusively that oral disease is prevalent in teenage users. In this study, it is reported that 47.4% of smokeless tobacco users have clinically detectable signs of oral sequelae (disease). This figure is frightening when considered in relation to the brevity of use.

It is imperative to recognize that it is no longer a question of "if" a person will suffer the effects of mouth cancer contraced from smokeless tobacco, but a question of "when". In order to protect our youth from permanent residual disability and disfigurement and even in some cases death, it is essential for the Kansas Legislature to enact legislation that will announce unequivocally our recognition of the cancerous effects of tobacco consumption.

3-19-84

Attach. # 5

ORAL TISSUE ALTERATIONS ASSOCIATED WITH THE TEENAGE USE OF SMOKELESS TOBACCO

PART I - CLINICAL FINDINGS

Robert O. Greer, Jr., D.D.S., Sc.D.*

Todd C. Poulson, D.D.S.**

UNIVERSITY OF COLORADO

SCHOOL OF DENTISTRY

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* Professor and Chairman, Division of Oral Pathology and Oncology

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Supported in part by NIH grants DE-06313 and CA-21098 and grants from the Colorado Division of the American Cancer Society and the Sands House Association.

Atch. 5

ABSTRACT

The practice of placing a small amount of chewing tobacco in the oral cavity and leaving it there for extended periods of time is known as "snuff dipping". Smokeless tobacco use appears to be finding its way onto middle, high school and college campuses as a socially acceptable, and vastly popular habit. Numerous reports have appeared in the literature that have described the oral changes that appear to be associated with the use of smokeless tobacco in adults. Such information is unavailable in the childhood age group. A study was therefore undertaken to determine the prevalence and frequency of oral hard and soft tissue alterations associated with the use of chewing tobacco in a teenage population. High school students in grades 9-12 were evaluated on a random basis. From a total sample size of 1,119 students 117 users of smokeless tobacco were identified. Four distinct lesions associated with smokeless tobacco use were identified clinically: (1) Hyperkeratotic or erythroplakic lesions of the oral mucous membranes; (2) gingival or periodontal inflammation; (3) a combination of oral soft tissue lesions and periodontal inflammation, and (4) cervical erosion of the teeth. Among the smokeless tobacco users, 113 were males and 4 were females. Fifty-seven, or 48.7 percent of the users had soft tissue lesions and/or periodontal inflammation, or erosion of dental hard tissues. Ninety-nine of the 117 users were Caucasian, 6 were Hispanic, 1 was black, 1 was Asian, 1 was American Indian and 6 failed to identify ethnic origin. Use ranged from 1 to 20 "dips" per day with an average time per dip of 30 minutes. Most users had been dipping for an average of 2 years and 12 different tobacco brands were identified.

REVIEW OF THE LITERATURE

Tobacco has been smoked, chewed and inhaled in various forms for over 500 years.[1,2] Christen in a 1982 review of the literature concerning the social history of smokeless tobacco use traced the historical development and folklore surrounding the use of smokeless tobacco to the time of the first voyage by Columbus to the Americas.[1] The use of smokeless tobacco has been, and remains, a world wide phenomenon. It's use in the United States has been well documented since the period of the Revolutionary War.[1] During the 1800's, three forms of smokeless tobacco became quite popular in the United States: dipping moist snuff, chewing loose-leaf chewing tobacco, and chewing block or plug tobacco.[1] In the 19th century the use of smokeless tobacco fell into disfavor largely because of the work of Koch, Pasteur, Lister, Ehrlick and others who popularized the "germ theory of infection", and characterized the tobacco chewing habit as unsanitary. A resurgence in the use of all forms of smokeless tobacco in the United States appeared in the 1970's. The sales of smokeless tobacco have increased about 11 percent annually since 1974 so that it is presently estimated that there are 22 million users in the United States alone.[3] Documentation of smokeless tobacco as an adult habit associated with lesions of the oral mucosa has been well delineated in the literature. However, in the decade of the 1980's smokeless tobacco appears to be finding its way onto middle school, high school, and college campuses as a socially acceptable and vastly popular habit that reflects a machco image. The revival of tobacco dipping and chewing as a popular social habit among adolescents has aroused renewed interest in the health controversy surrounding its use. [2]

Smokeless tobacco is popularly used in one of two forms; either as dipping tobacco (snuff) or as rough cut chewing tobacco. Snuff dipping consists of placing a pinch of powdered tobacco between the cheek and gum, whereas using chewing tobacco consists of placing leaf tobacco or a plug of tobacco in the oral mucosa near the inner cheek. A "chaw" is a golf-ball-sized quid of leaf or plug tobacco on which the chewer sucks. [3] A "quid" is a small portion of any smokeless tobacco that is held in the mouth for dipping or chewing.

Well recognized oral mucosal reactions have been documented in individuals who use smokeless tobacco in any of its forms. The relationship of the clinical picture of adult snuff dipper's lesions to their histopathologic appearance has been thoroughly studied in Scandinavia,[4-6] the United States,[7,8] and South Africa.[9] These studies are all largely confirmatory in that they show that oral leukoplakic patches appear in the anatomic region where the smokeless tobacco is most commonly placed. Christen[1] has reported that smokeless tobacco can produce significant effects on the hard tissues of the oral cavity in adults including discolored teeth and fillings and abrasion of the incisal and occlusal surfaces of the teeth. He also reported decreased ability to taste and smell, gingival recession, and advanced periodontal disease.

The question of the potential carcinogenicity of smokeless tobacco has received considerable attention in the medical and dental literature, and numerous investigators have examined the possible association of smokeless tobacco with oral cancer, especially verrucous carcinoma.[5-16] Christen[2] suggests that there is a supportable link between the use of smokeless tobacco and oral cancer and he further speculates that over 600 cases of oral, pharyngeal or laryngeal cancer can been directly traced to smokeless tobacco use.

Other investigators, however, have found no premalignant or malignant changes related to the use of snuff or chewing tobacco.[6,17,18] Numerous scientists, however, have suggested that there may be a substantial link between the use of smokeless tobacco and oral epithelial dysplasia.[3,4] Sundström and associates[11] recently reviewed the clinical and histological characteristics of 23 oral carcinomas in the anterior vestibule of snuff dipping Swedish males who were an average age of 76 years. Examples of verrucous carcinomas as well as ulcerating, infiltrative squamous cell carcinomas were encountered in their study. Widespread oral leukoplakia, dysplasia and second primary carcinomas were also recorded.

Axéll and associates, in 1976 were responsible for establishing standardized clinical guidelines for grading the mucosal changes seen in adult snuff dippers.[18]. More recently Hirsch and co-workers[4] reviewed the clinical, histomorphologic and histochemical features of snuff induced lesions in 50 habitual adult snuff dippers. They graded the lesions according to the four point scale developed by Axéll, and found that all of the lesions that they charcterized were hyperkeratotic to some degree with colors ranging from white to yellow or brown and surface textures that showed variations from slight wrinkling to deeply furrowed or leathery. These investigators indicated that the presence of dysplastic changes could not be predicted by means of the parameters which characterized the snuff habit clinically. Nonetheless, they were able to document nine instances of dysplasia in their study of 50 adult patients.

Although there has been considerable scientific investigation of the clinical and histomorphologic changes associated with the use of smokeless tobacco in adults there is no such information available for children and adolescents. This paucity of information concerning the oral hard and soft

tissue changes associated with the use of smokeless tobacco in a teenage population coupled with the current resurgence in the use of all forms of smokeless tobacco in the United States precipitated the present investigation.

MATERIALS AND METHODS

One thousand-one-hundred and nineteen teenagers in the metropolitan Denver public schools in grades 9-12 were examined to determine the incidence and frequency of oral tissue alterations associated with the use of smokeless tobacco. The students completed a questionnaire with eight specifically selected questions designed to identify the number of years with the habit, daily exposure, brand of tobacco used, site of application, smoking and drinking habits, subjective symptoms, and frequency of dental care (Table 1).

Two examiners previously trained in the diagnosis and indexing of oral lesions associated with the use of smokeless tobacco products performed oral hard and soft tissue examinations. All examiners performed the examinations without seeing the questionnaire completed by the students so as not to institute examiner bias.

The clinical appearance of smokeless tobacco induced lesions was graded using a modified method of that developed by Axéll and associates.[18] An exhaustive evaluation of the histomorphologic alterations, electron microscopic findings, and histochemical changes seen in the mucosa of teenage smokeless tobacco users is the subject of an ongoing scientific investigation, which will be presented as a second stage of this study.

RESULTS

Age, Sex and Clinical Appearance

The total sample of 1,119 patients included 522 males and 597 females. One-hundred-seventeen individuals (10.45% of the total sample) admitted to

using smokeless tobacco. One-hundred-thirteen users were male and four were female. Table 2 reflects the age and sex distribution of smokeless tobacco users. Fifty-seven (48.7%) of smokeless tobacco users had lesions of the oral hard or soft tissues. The lesions were easily clinically detectable and were graded using a modified method of that established by Axéll and associates[18] in the following manner:

Degree 1: a superficial lesion with color similar to surrounding mucosa with slight wrinkling and no obvious thickening.

Degree 2: a superficial whitish or reddish lesion with moderate wrinkling and no obvious thickening.

Degree 3: a red or white lesion with intervening furrows of normal mucosal color, obvious thickening and wrinkling.

Fifty individuals had oral mucosal lesions that could be categorized as degree 1, degree 2, or degree 3 (Table 3). Examples of each of the various grades of mucosal lesions are seen in figures 1, 2, and 3.

In addition to evaluating the clinical appearance of snuff induced lesions all lesions were classified according to their texture, contour and color. These mucosal alterations are described in Table 4. The vast majority of the lesions were white, corrugated and raised. We found no evidence of black, brown or yellow lesions in any of the patients.

In addition to oral soft tissue alterations, involvement of the periodontium was evaluated. Tobacco associated periodontal degeneration was defined as tobacco-site-specific gingival recession with apical migration of the gingiva to or beyond the cemento-enamel junction with or without evidence of inflammation clinically. Seven individuals had periodontal lesions alone, while 23 individuals were identified to have a combination of mucosal lesions and periodontal involvement. (Fig 4) One case of cervical erosion

was identified. (Fig. 5)

Anatomic Location

Table 5 shows a regional block scattergram identifying the most prominent anatomic locations of the lesions identified in teenage smokeless tobacco users. All lesions arose directly in the area of quid placement; the vast majority of the lesions were found in the anterior mandibular muccobuccal fold extending from cuspid to cuspid.

Symptomatology, Ethnicity and Social Habits

Six of the 117 of smokeless tobacco users had symptoms. Symptoms were broadly defined as an awareness of mucosal changes or gingival recession on the part of the patient. None of these individuals had pain or discomfort, although one subject discontinued use of snuff due to "irritation" of his mucosa that was unrelieved by moving the tobacco quid to different locations in the oral cavity.

The ethnicity of the smokeless tobacco users is tabulated in Table 6. Ninety-nine users were Caucasian, six were Hispanic, one was black, one was Asian, and one was American Indian. Six individuals failed to identify their ethnic origin. Chewers used 12 different brands of smokeless tobacco. Ninety-six of the total of 117 users identified the brand of smokeless tobacco they used; 52.8% of these used one brand of smokeless tobacco. The majority of the smokeless tobacco users (79.17%) indicated that they used one of two specific brands of tobacco. More than half of the patients (62%) admitted to occasional use of alcohol, although it was difficult to quantitate the amount of alcohol that was used. Only three individuals who were smokeless tobacco users also smoked cigarettes. Eighteen individuals gave a positive history for alcohol use, cigarette smoking and the use of smokeless tobacco. No significant differences with regard to clinical grading of lesions could be found either between patients with multiple

habits (dipping, smoking and drinking) and those who only used smokeless tobacco or between patients who used different brands of smokeless tobacco and those who used one brand only. Over 69% of the smokeless tobacco users had had a full mouth dental examination in the past year. The level of dental care recorded for smokeless tobacco users is shown in Table 7.

EXPOSURE

The average exposure among users of smokeless tobacco with oral sequelae was determined to be 170 minutes per day. In individuals who chewed or dipped but had no oral signs or sequelae an average exposure time of 59.3 minutes per day was calculated. The duration of use among each of these groups is shown in Table 8.

DISCUSSION

The patients examined during this investigation represented quite a different population from those who have traditionally been studied. Most had been smokeless tobacco users for a short duration (average use 3.3 years) when compared with the studies of Roed-Petersen and Pindborg (average use 22 years) and Axéll and associates (average use 23.8 years) in adults.[5,18] We were unable to duplicate the findings of Axéll and others,[18] or Hirsch and others[4] who established four degrees of oral mucosal alteration associated with smokeless tobacco use, the most severe change being a white to yellowish-brown, heavily wrinkled lesion with intervening deepened red furrows and/or heavy thickening. The reason for this failure is unquestionably related to the fact that nearly all previous authors have evaluated adult populations where the tobacco users have had a snuff dipping habit ranging from 16 to 20 years. The three degrees of mucosal change that were noted in our study represent a new classification which we feel should be applied to individuals who have used tobacco four years or less.

Hirsch and associates reported that the individuals in their recent study of snuff induced lesions in adult Scandinavians kept the tobacco quid in their mouth 8.5± 4.9 hours.[4] Individuals in our study admitted to an average daily exposure of less than three hours. Although we were unable to determine a daily consumption in terms of the number of grams of tobacco used we expect that the consumption in the teenage population studied in no way approached the total consumption of 14 grams per day reported by Axell and others,[18] or Hirsch and co-workers[4] in adult users.

The present study documents that the use of smokeless tobacco among teenagers is overwhelmingly a male habit. Roed-Peterson and Pindborg[5] reviewed a sample of 450 adult Danish patients with oral leukoplakia, 32 of whom had snuff related lesions and demonstrated that the habit was predominately seen in a males as well. However, an abundance of reports in the American literature indicate that the habit is widespread among adult females.[12,15] Seventy-five percent of 15,000 American snuff users surveyed by Smith and others were females[7]. We suspect that this reported female predilection probably represents to some extent regional population sample bias.

Christen and others[3] reported a high prevalence of abrasion on the occlusal and incisal surfaces of teeth among adult tobacco chewers and snuff dippers in the United States. These investigators also reported a high frequency of gingival recession and periodontal destruction associated with the use of smokeless tobacco. van Wyk[9] demonstrated similar findings in South African patients who were confirmed snuff dippers. We found no evidence of occlusal or incisal abrasion of the teeth in any of the 117 teenagers who admitted to using smokeless tobacco. Although we were able to document tobacco associated periodontal deterioration, the advanced periodontal destruction and loss of teeth that have been reported adjacent to regions

where the tobacco quid is held in long-term smokeless tobacco users[12,19] was not demonstrated. It appears that such severe hard and soft tissue changes are related to long-term use of the tobacco product and are features classically seen in an adult population.

Although we did document one instance of cervical erosion in the study it was was deemed an aberrant finding. We could not specifically relate the cervical erosion to excessive use of smokeless tobacco by the patient or to a specific brand of tobacco although we favor this as the cause in what was an otherwise healthy oral cavity since it was identified in the anatomic site where the tobacco quid was routinely placed.

We found no evidence of tobacco associated dental caries. It has been speculated that the relative paucity of caries seen in heavy tobacco chewers may largely be due to the accelerated salivary flow that the tobacco stimulates. It is postulated that the accelerated flow causes a physical cleansing action and mild buffering action that inhibits plaque and cariogenic material aggregation. Christen[2] has further suggested that many smokeless tobacco products contain fluoride in levels ranging from .91 ppm to 2.01 ppm. The fluoride may also be instrumental in suppressing dental caries in smokeless tobacco users. There is, however, no universal agreement among investigators that smokeless tobacco is innocuous with regard to caries formation. Sitzes[20] reported that several patients who chewed sweetened smokeless tobacco had evidence of cervical caries.

The present study demonstrates a marked predominance of white male chewers. This ethnic distribution was quite striking and we consider it unrelated to an ethnic sample bias since 83% of the participants in the study were from the Denver Public school system, a school system that has had mandatory busing since 1973 with a resultant racial balance among the

majority of high school student bodies.

In various parts of the world smokeless tobacco has different constituents, thus the abrasive quality, tobacco content, chemical components, and manufacturing process may vary widely.[5] In Scandinavia, wet snuff, which is highly alkaline (pH 8-9) is used almost exclusively. The dry tobacco used in the United States is not nearly as alkaline. It has been suggested that epithelial changes found in Swedish and Danish snuff users represent direct tissue damage probably related to the high alkaline reaction of Scandinavian wet snuff.[18] Pindborg and colleagues[10] accept the theory that the vacuolated cells seen in the histopathologic material from Swedish and Danish snuff users may be the result of the highly alkaline product, however, the development of characteristic chevron-like keratinized spikes which they have suggested are histologically characteristic and specific for mucosal damage from pipes, snuff and hooklis must have a different etiology since they are found in cigarette smokers as well as smokeless tobacco users. We also suspect that these chevron-like keratinized spikes appear as a function of tobacco exposure over time and very likely may be absent in individuals such as teenagers, who have used tobacco for only a short duration.

Pindborg and associates[10] have described a characteristic pumice-like keratinization of the oral mucosa in individuals who are long-term smokeless tobacco users. This pumice-like change has been characterized clinically by a homogenous white patch with elevated keratinized striae. The pumice pattern has been seen solely on parts of the oral mucosa which normally are nonkeratinized. In none of our 50 patients who had discernable oral mucosal lesions that were related to the use of smokeless tobacco were we able to demonstrate this characteristic pumice type of appearance. In 13.5 percent of the smokeless tobacco users we were able to detect a granular texture to

the mucosa which is perhaps similar to what Pindborg has defined as a pumice-like quality. However, in those patients who had a granular quality to the mucosa none had the deep furrowing that is characteristic of the pumice pattern described by Pindborg and associates.

Hirsch and associates[4] recently attempted to correlate snuff habits with the clinical severity of oral lesions as well as with certain superficial and deeply located cell changes in the epithelium and connective tissue. They found that the incidence of keratinized lesions, sialadenitis and mild dysplasia were higher than previously reported in the literature. These investigators emphasized, however, that the presence of dysplastic changes could not be predicted by means of the parameters which characterize the snuff habit or from the clinical grading of the lesion. The authors noted that the mild dysplasia seen in their study did not necessarily mean that the lesions were precancerous since similar dysplastic epithelial change may be found in noncancerous lesions according to the World Health Organization's collaborative study on oral precancerous lesions.[21] However, in a retrospective study of snuff dipper's mucosal alterations, Axéll and others,[22] demonstrated a clear correlation between snuff dipping and oral cancer in Sweden, a finding supported in earlier studies in various other countries.[11,13,15]

Christen, perhaps more than any single investigator, has adamantly maintained that smokeless tobacco causes oral cancer. He supports the concept that verrucous carcinoma is associated with the use of smokeless tobacco by noting that nitrosonornicotine (NNN) the first organic carcinogen isolated from unburned tobacco is found in smoking tobacco, chewing tobacco and snuff in high concentrations, between .03 and 90ug/g of dry tobacco.[2,23] The suggestion that nitrosonornicotine may be the carcinogen responsible for

verrucous carcinoma development in smokeless tobacco users, and the suggestion by Pindborg[10] that smokeless tobacco induced oral epithelial changes may be predicted on the basis of histologic findings all deserve further study. Thermal irritation has been implicated as one of the possible etiologic factors associated with dysplastic changes in the mucosa of hookli smokers;[2,10] however, thermal irritation alone cannot be the sole explanation for the oral changes since similar lesions are seen in tobacco chewers and snuff dippers.

The early clinical changes that have been noted in the present study are thought largely to be the result of mucosal irritation from the topically applied tobacco product. Bernstein and Carlish reported similar diffuse, filmy, white lesions of the oral mucosa in several patients with histories of excessive use of Listerine mouthwash.[24] In their studies remission of the lesions occurred two weeks after the product was discontinued. They developed a control animal model in hamsters to study the effects of prolonged oral contact with Listerine and found that after 42 days of application every animal had developed clinical evidence of diffuse, filmy, white, corrugated lesions of the oral mucosa. The authors postulated that the response was purely one related to physical contact of the product with the mucosa.

Half of the patients in our study who admitted to smokeless tobacco use had no oral lesions. We were able to elicit from thorough history taking that two of the individuals in our study who had used smokeless tobacco were aware of a "white callous" that disappeared when they discontinued using the product which suggests that the mucosal lesions are reversible.

From the response to our question concerning the level of dental care afforded the patients in this study it was apparent that the vast majority of the patients (69.3%) had had access to dental care in the form of a routine

full mouth examination during the previous year. We were unable to determine whether tobacco related mucosal lesions were evident in any of the patients during those exminations. The degree of difficulty present in recognizing Degree 1 lesions can be extreme even among examiners well versed in recognizing such subtle mucosal alterations. An educational campaign to advise dentists of these early mucosal changes may prove quite beneficial.

Although this study documents that oral tissue changes are unquestionably associated with the use of smokeless tobacco in teenagers, additional studies are deemed necessary to study the histomorphologic, electron microscopic and histochemical changes evident in oral mucosa associated with the precipitant increase in smokeless tobacco use among American teenagers. Pursuant to that goal, a second phase of this study has been designed to investigate these varied parameters and compare them with previously published information concerning similar changes seen in adult patients.

SUMMARY

The practice of placing a small amount of chewing tobacco or snuff in the oral cavity and leaving it there for extended periods of time appears to be finding its way onto middle school, high school and college campuses as a socially acceptable and vastly popular habit. Numerous reports have appeared in the literature that describe the oral changes that are associated with the use of smokeless tobacco in adults. Such information has previously been unavailable in adolescents and teenagers. A study was undertaken to determine the prevalence and frequency of oral tissue alterations associated with the use of chewing tobacco in a teenage population as well as to determine the relative exposure to the tobacco in terms of minutes per day, the specific brands of tobacco used, the common anatomic sites for placing of

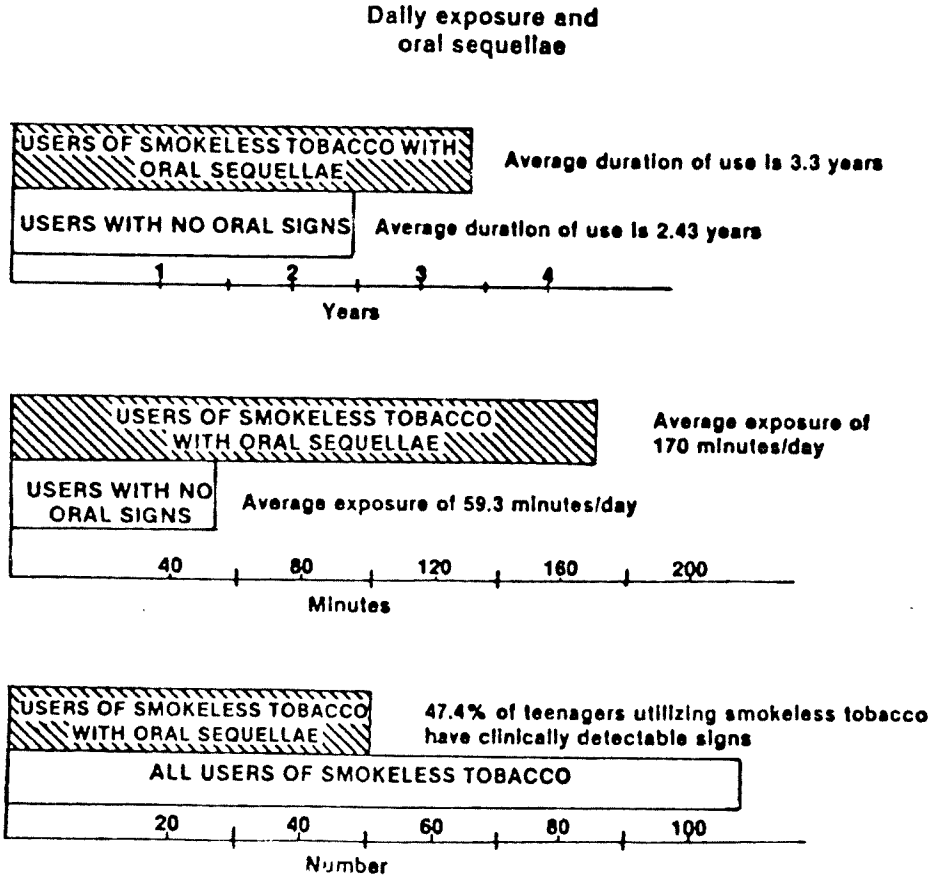
#5

the tobacco quid, smoking and drinking habits, and subjective symptoms. From a total sample size of 1,119 students 117 users of smokeless tobacco were identified and 57 individuals with oral lesions were identified.

LEVEL OF DENTAL CARE
(How recently the subject had received a full-mouth examination by a dentist)

less than 6 months	55
6 months to 1 year	24
1 to 2 years	22
2-4 years	3
5 or more years	10

Among teenage users of smokeless tobacco, 69.3% had been to a Dentist in the last year



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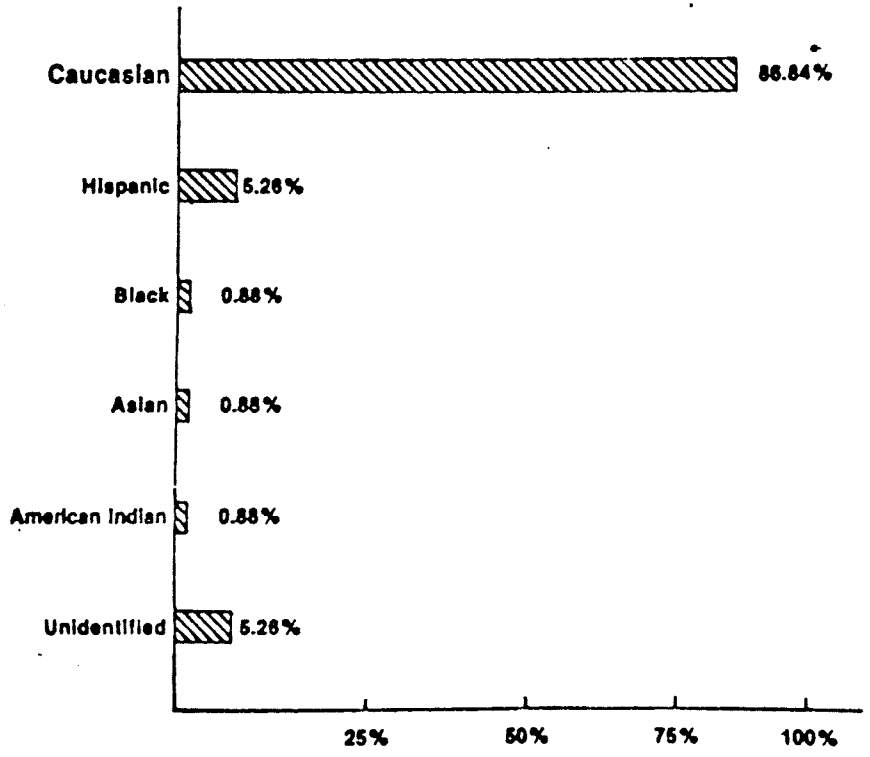
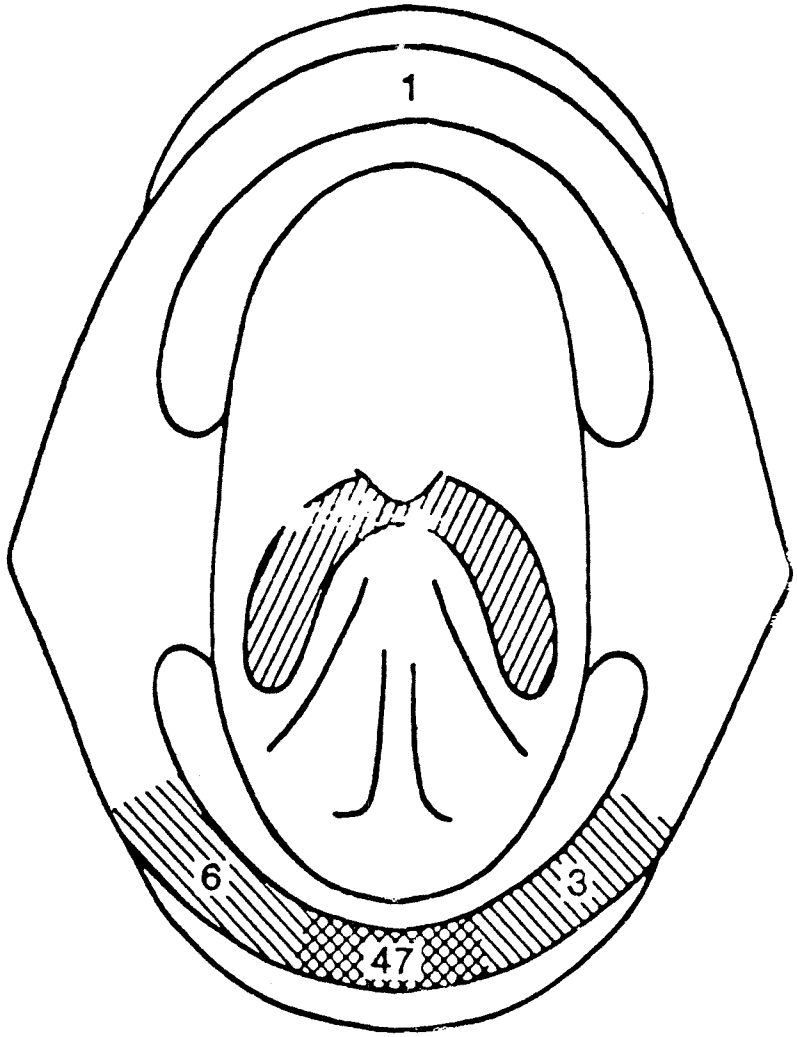
RACIAL DISTRIBUTION AMONG TEENAGE USERS OF SMOKELESS TOBACCO



Anatomic Locations of Periodontal and Mucous Membrane Lesions in Smokeless Tobacco Users



#2

Classification of lesions in fifty patients with mucosal alterations only (excluding periodontal involvement)

	Number	Percentage
Degree I	25	50%
Degree II	18	36%
Degree III	7	14%
	50	100%

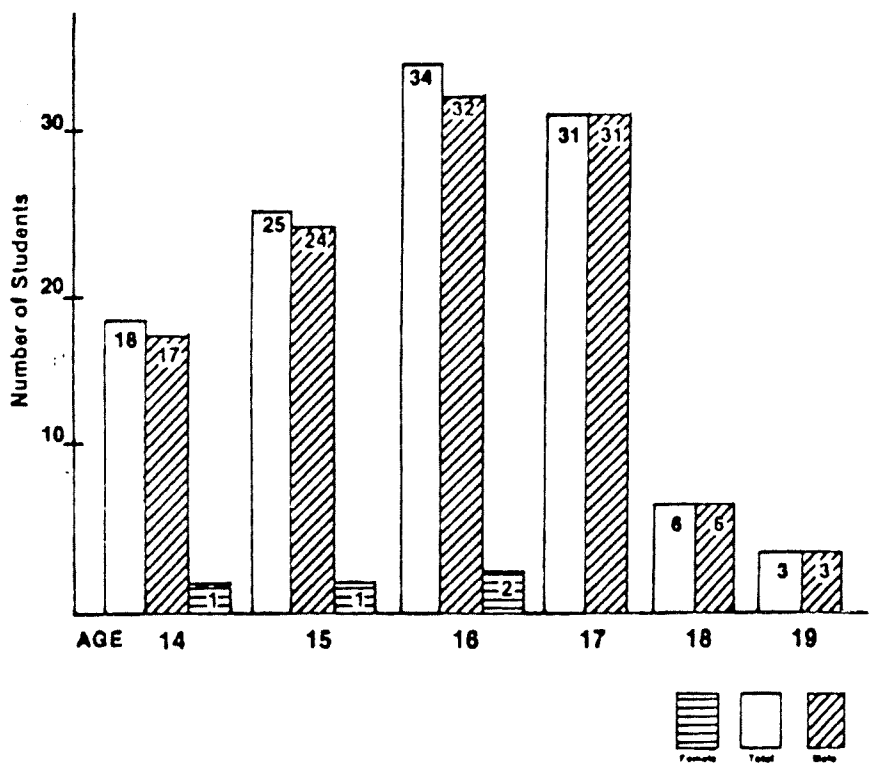
CHARACTERISTICS OF MUCOSAL ALTERATIONS ASSOCIATED WITH THE USE OF SMOKELESS TOBACCO

TEXTURE:
48% smooth
13.5% granular
38.5% corrugated

COLOR:
81% white
9.5% red
9.5% red and white
none were brown or black

CONTOUR:
52% raised
44% flat
4% cratered

SEX AND AGE DISTRIBUTION AMONG 117 TEENAGE USERS OF SMOKELESS TOBACCO



QUESTIONNAIRE

Name: _____ (last) _____ (first) _____ (mi)

Address: _____

_____

Telephone _____

Patient Age _____

Name of Site _____

Sex (circle one) Male Female

Ethnic Origin

____ Asian
____ American Indian
____ Black
____ Caucasian
____ Hispanic

PLEASE ANSWER THE FOLLOWING QUESTIONS (This information will remain confidential)

1. When was the last time you had a full-mouth examination by a dentist?
   - less than 6 mos. ago
   - 6 mos. to one year ago
   - 1-2 years ago
   - 2-4 years ago
   - 5 or more years ago
2. Do you ever use chewing tobacco (snuff)?
   - ___ Yes
   - No. If "No", you need not answer any more questions. PLEASE TAKE THIS FORM TO THE EXAMINER.
   - If "Yes", please continue with the questionnaire
3. When did you first start using chewing tobacco?
4. How many times a day do you "chew"?
5. a. How long do you keep each chew in your mouth?
   b. On the average, what is the total length of time you have tobacco in you mouth per day?
6. a. What brand of chewing tobacco do you use?
   b. Do you use this brand all the time? ___Yes ___No
   c. What other brands have you used?
7. Do you ever drink alcohol? ___Yes ___No
   If "Yes", what do you drink, and how often?
   - ____ Wine ____ times per day ____ times per week
   - ____ Beer ____ times per day ____ times per week
   - ____ Hard Liquor ____ times per day ____ times per
8. Do you ever smoke cigarettes? ___Yes ___No
   If "Yes", how many cigarettes do you smoke per day?
   - ____ less a few
   - ____ ½ pack
   - ____ one pack
   - ____ more than a pack

Thank you. The dental examiners will complete the remainder. Please remember that the exam you are about to receive is a screening and is not a complete dental examination.

I. PERIODONTAL CONDITION

No overt signs of disease evident	Treatment indicated but not urgent.	Treatment needed immediately

II. DENTAL DECAY

No overt signs of disease evident.	Treatment indicated but not urgent.	Treatment needed immediately
No gross decay or suspicious areas.	Incipient decay defective fillings	

III. ORAL PATHOLOGY

No signs of obvious suspicion upon visual screening exam.	Area of suspicion is evident requiring further evaluation.

Site _____

COLOR	CONTOUR	TEXTURE
White	Raised	Smooth
Red	Flat	Granular
Combination (mixed)	Cratered	Corrugated
Brown or Black		

Location _____

Number ____ _____

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3-1-84

Attach. #6

SENATE BILL No. 846

March 19, 1984.

Dear Honorable Gentlemen,

My firm, Capital Recovery Company, is in the business of searching for lost assets, of all kinds, then finding the proper legal claimants to these funds.

We have no problem with a bill that will help regulate our industry. (We Don't Want This Bill Killed). We feel there is a need for it and welcome it with a few corrections.

The first is that 24 month waiting period;
After the state publishes the name of an individual in the newspaper, anyone who is professionally tracking down a lost owner, according to this bill, has to wait two years to contractually enter agreement with the legal owner to alert him of the lost asset. (This two year holding period is ridiculous). California, on ~~the other hand~~ requires you to wait two months. This gives an individual, who is going to be alerted by the efforts of the state, eights weeks to respond to the article.
NOBODY READS NEWSPAPERS TWO YEARS OLD!

The second provision not allowing a fee in excess of 10%;
We believe that the law should read, "not in excess of 30%."
The overwheming majority of our claims are definately under $1,000.00 (over 95%). And these are the ones we work on a regular basis. Sure, there are some funds over $1,000.00 but they are very few, and very far between. The time it takes to trace an owner is no differant than any other industry-it costs money. There are travel costs, attorney fees, court fees, phone bills, fees for death certificates, wills and probate records. These are common expenditures we encounter everyday and PAY IN ADVANCE.
A 10% maximum is UNFAIR and most certainly, will effectively kill the chance of the "little guy" ever being alerted to his property-the ones who have two or three hundred dollars due him, or less, for he cannot be economically ~~seeked~~ out, at 10%.
WHAT DO YOU FEEL IS BETTER FOR YOUR CONSTITUENT?

The third provision is good-except that it puts the "cart before the horse".
We suggest that the bill read

> Agreement be in writing and signed by the owner and full disclosure of nature and value of the property along with the name and address of the holder be given, in writing BEFORE A CLAIM IS SUBMITED to the holder.

This amendment will not only protect the legal owner from an unscrupulous person who might understate the true value of the property but also honors the honest individuals' right to expect a reasonable fee for his efforts and service. (Remember, under this last section of the bill, an owner has due recourse under the law to contest a fee, if he thinks it unfair).

Respectfully,

The Spirit of All Good Heir Tracers
In The State of Kansas.
And
CAPITAL RECOVERY COMPANY.

Atch 6

Session of 1984

SENATE BILL No. 846

By Committee on Ways and Means

3-13

AN ACT concerning the disposition of unclaimed property; relating to agreements for the recovery of property; amending K.S.A. 58-3932 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 58-3932 is hereby amended to read as follows: 58-3932. All agreements to pay compensation to recover or assist in the recovery of property reported under K.S.A. 58-3912, and amendments thereto, made within 24 months after the date payment or delivery is made under K.S.A. 58-3914, and amendments thereto, are unenforceable. *Such an agreement made more than 24 months after payment or delivery is required pursuant to K.S.A. 58-3914 and amendments thereto is valid if the fee or compensation agreed upon is not in excess of 10% of the recoverable property and the agreement is in writing and signed by the owner after disclosure in the agreement of the nature and value of the property and the name and address of the person or entity in possession of the property. Nothing in this section shall be construed to prevent an owner from asserting, at any time, that any agreement to locate property is based upon an excessive or unjust consideration.*

Sec. 2. K.S.A. 58-3932 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Amendments

and amendments thereto, made within 2 months after the date

the fee or compensation agreed upon is not in excess of 30% and the agreement is in writing and signed by the owner. After such agreement is signed the nature and value of the property and the name and address of the holder of the property be given to the owner of the property, in writing, before a claim can be submited to the holder.

#1

Reply to:

Mr. Philip P. Skow
P.O. Box 37
Carbondale, Kansas
-66414

CAPITAL RECOVERY COMPANY

RE: Unclaimed Asset due: _____

Dear _____,

We are very happy to inform you that you appear to be legally entitled to an unclaimed asset.

Our firm is in the business of searching for abandoned or lost assets of all kinds, then finding the proper legal claimants to these funds. We believe that you are entitled to part or all of such a fund.

In exchange for our research and services, we receive a percentage of the collection, commonly called a contingent fee. Accordingly, we use an agreement form in order to 1. act in your behalf to secure this fund for you and 2. to guarantee us our fee for locating you and helping you to claim your money. The asset is usually a windfall that would not be discovered or collected without our research and service. I have enclosed our standard form #3 agreement for you to sign and return to us. You will notice that I have indicated the approximate amount (approximate because if there is a cost involved in the claiming of the fund it is subtracted from the fund). The power of attorney covers only this particular asset-it is a limited power of attorney which enables us to act in your behalf in regards to this fund.

In signing the agreement form you are not obligated in any way unless we produce the fund for you.

As soon as we have received the form #3 agreement from you we will INFORM YOU of the EXACT SOURCE of this money and proceed to collect it for you by supplying you with any forms that might be needed. Disbursement of the check usually takes 45 days from the time we receive the agreement.

Please feel free to call us if you have any further questions. Telephone #913-564-7755. (The best time to call if necessary is between 8:00a.m. to 10:00a.m. Central time).

Sincerely Yours,

President

"We're in the business of helping people recover their inheiritance."

Form #1

#

CAPITAL RECOVERY COMPANY

QUESTION AND ANSWERS

(This information is furnished to clear up commonly raised questions).

1. WHY DID I RECEIVE THIS LETTER?
We believe that you are entitled to claim part or all of an unclaimed inheiritance or dormant asset.

2. AM I REALLY ENTITLED TO SOMETHING OR IS THIS A GIMMICK?
Our unique firm is straightforward-we investigate situations involving unclaimed estates and other dormant items. We reveal and assist you in the collection of this asset which has been dormant for years. In return for this, you agree to split the collection with us on a percentage basis.

3. I DONT LIKE YOUR FORMS. CAN I PUT THE DEAL IN MY OWN WORDS?
Yes, the forms are used for convenience and to save lots of time. So long as you state our proposition as given on our sheet, more or less, we're agreeable.

4. IF I SIGN YOUR AGREEMENT AND IT TURNS OUT THAT a) I already collected it, b) I am in the process of collecting, c) I know all about the situation and am fully aware of all my rights-then do I still owe your firm a split?
Certainly not. However, as soon as we make disclosure, we would appreciate it if you would let us know the facts lest we think you are trying to circumvent our fee. We would not want a fee unless we really alerted you to a bona-fide unknown or forgotten item.

5. IF IT TURNS OUT THAT I AM THE WRONG PERSON, WILL I BE SUBJECT TO ANY LIABILIITY OR COSTS?
No. Not unless you make fraudulent statements to us. When we make disclosure we expect you to be truthful with us. We would never knowingly present a false claim to a court or trustee.

6. IF I RETURN THE AGREEMENT, WILL YOU THEN GIVE ME ALL THE DETAILS?
Yes, by return mail (so everything is in writing) and usually we like to follow up with a least one phone call. The only exception being when several heirs are entitled to the same asset. We do not reveal anything until all are signed up. To do otherwise would be to give some heirs a "free ride" at our expense.

7. DO I HAVE TO DO BUSINESS WITH YOU?
No. But if you don't, you will probably never hear of the asset due you.

I am sure that you will be highly pleased with our service.

Sincerely,

Mr Philip P. Skow

form #2

#6

AGREEMENT

Return to:

Mr.Philip P. Skow
P.O. Box 37
Carbondale, Kansas
-66414.

Dear Sir:

By this letter I _____ give you Philip P. Skow full power of attorney to act in my name, to collect and disburse funds or property due me with particular reference to and only to:

Sign here _____

_____
Address

_____
City

_____
Telephone

Subcribed and sworn to before me this _____day of _____, 19___

_____ Seal
Notary Public

FEE MEMORANDUM:

In consideration of your successful efforts to notify me of dormant assets which I _____ may be entitled, and your promise to direct my claim into proper channels, I hereby assign to you Philip P. Skow _____ of the net collection. It is understood: 1. Claimant will cooperate by executing documents needed to complete the claim, 2. UNLESS A COLLECTION IS MADE THERE WILL BE NO CHARGE TO CLAIMANT WHATSOEVER.

Sign here

_____

Claimant/finder contract
Form #3

#1

CAPITAL RECOVERY COMPANY

Reply to:

Mr. Philip P. Skow
P.O. Box 37
Carbondale, Kansas
66414.
Telephone: #913-564-7755

RE:

Dear

Thank you very much for returning our agreement relating to the dormant or unclaimed asset. We are pleased to inform you that the situation out of which you will soon be getting payment is as follows:

We work only cases having assets which are dormant or unclaimed for some years. Since most states have "escheat" or abandoned property laws providing for transfer of inactive items to them after periods of from two to twenty years, we presume that you have been alerted to a situation wherein you were not fully aware of your rights.

For final processing we will need your cooperation in providing the following documents marked below:

Please return the above information as soon as possible to permit us to complete the collection of this asset for you.

Again, thank you for your cooperation.