CONFIDENTIAL

MADISON SQUARE GARDEN
The World's Most Famous Arena

EMPLOYEE PROFILE

— SALARY CHANGE
PROMOTION ☐
ADJUSTMENT ☐
MERIT ☐
— TRANSFER

X TERM/LAYOFF
— PERSONAL INFORMATION CHANGE
— LEAVE OF ABSENCE

— RETURN FROM LEAVE
— TITLE CHANGE
— OTHER

EFFECTIVE DATE: 06/14/01 | EMPLOYEE ID:

LAST NAME	FIRST NAME	MIDDLE INITIAL	STREET ADDRESS
[redacted]	[redacted]		

APT#	CITY	STATE	ZIP	HOME TELEPHONE

CODE	DEPARTMENT NAME	EMP STATUS	ACTION REASON	EMP ACTION DESCR
404070	MSG Technical Operations	A	CTR	Contractual Adjustment

Term-falsification of records

FLSA STATUS: EXEMPT ☐ N / NON-EXEMPT ☐

EMPLOYEE CLASS: ADMIN ☐ / CASUAL ☐ / SEASONAL ☐ / TEMPORARY ☐ / UNION REG ☐ U

WORK STATUS: TEMP ☐ / REGULAR ☐ R — FULL TIME ☐ / PART-TIME ☐ F

COMMENTS: Contractual pay - 2 weeks in lieu of notice

LOCAL #	JOB CODE	REASON	JOB TITLE	PERF CODE	PAY GROUP	SALARY GRADE	ANNUAL SALARY	MJC
L12	TV001		TV Technician		WC1		84,188	3

BASE SALARY	AMOUNT OF INCREASE	% INCREASE	SAL CHG REASON	SALARY EFF DATE	LAST REVIEW DATE	NEXT REVIEW DATE
1619	38.50	2.44		06/01/01		

SUPERVISOR	BENEFIT PROGRAM	EFFECTIVE DATE	HIRE DATE	SENIORITY DATE	TERM DATE
Shaw, David L	L12	10/11/82	12/20/82	12/20/82	6/25/01 upon approval

DEPARTMENT (SUPERVISOR) / DIVISION HEAD	DATE	HUMAN RESOURCES / PRESIDENT & CEO	DATE
S Gabriela	JUNE 18, 2001	[signature]	6/19/01

Ernie Stein 6/28/01

MSG 41116

MADISON SQUARE GARDEN
The World's Most Famous Arena

To: Aimee Kaye

From: Marilyn Hausner

Subject: [redacted]

Date: May 22, 2001

Phone: 465-6343

Copies:

As we discussed, Louise Viney, Director Benefits had a conversation wit[redacted] TV Technician, Local 1212 during the week of April 2, 2001 in which [redacted] indicated that he wanted to remove his "wife" as a beneficiary to the 401k plan. Louise explained that she would be required to sign a waiver allowing us to process this request. [redacted] went on to explain that she was never really his wife but rather they had lived together for 17 years. He then asked if Louise could "keep this quiet and between them" rather than her needing to let anyone know about this situation. Louise of course, explained that she could not do that.

On April 17, 2001 I met with Dave Shaw, SVP Technical Operations, Louise Viney, [redacted] and Dom Spada, Union Shop Steward. In that meeting [redacted] explained that he and his wife lived together for 17 years, had raised a child together and in no way was he trying to be deceptive towards MSG. He did state however that he files his income tax as head of household and not jointly.

As a result of this, the cost of the benefit coverage is estimated at a minimum of approximately, $72,000 for the past 10 years for family coverage. This does not include the cost of claims.

Please let me know if this is okay to proceed.

REDACTED

Aetna

Group Insurance Enrollment Information

138

☐ New Enrollment ☐ Rehired Employee or Reinstatement of Coverage *Use Instructions on Reverse*

Small Business Market

1. Employer Name: Madison Square Garden, L.T.

4. Employer's Address (Street, City, State, Zip Code): 2 Penn Plaza New York 1/101/1211

2. Control Number: 062515 | Suffix | Account | 3. Claim Office Code

5. Employee Name (Last, First, Middle Initial): [redacted]

6. Social Security Number | 7. Sex ☐M ☐F | 8. Birthdate Month Day Year

5a. Employee Address (Street, City, State)

5b. Zip Code

9. Beneficiary Designation (Example: Mary Jane Doe, Mrs. Jane Doe) Full Beneficiary Name: [redacted]

10. Relationship of Beneficiary: WIFE

11. Occupation: EMPLOYEE TV ENGINEER

12. Was the employee cove[redacted] months? ☐ Yes ☐ No If yes, complete below.

Previous Insurance Company Name	Policy or Group Number	Effective Date of Prior Coverage	Termination Date of Prior Coverage	Insurance Company Phone Number
AETNA				

13. If coverage was as a dependent, the following *must* be provided:

Name of the person under which you were insured	That Person's Social Security Number	Will this coverage be kept after Aetna coverage begins?
		Employee ☐Yes ☐No / Dependent ☐Yes ☐No

14. Is the group insurance for this employee or any of their dependents being continued under COBRA, Extension of Benefits, or as a dependent of a deceased employee? Employee ☐Yes ☒No, Dependents ☐Yes ☐No. If Yes, please provide the name of the individual on continuation and the type of continuation: What was the effective date of the continuation? Month Day Year

15. Earnings Per	16. Plan Number	17. Full Time Employment or Return to Work Date (*must* be completed) Month Day Year	18. Effective Date (Employment Date Plus Probation Period) Month Day Year	19. Employment Status Active Retired	20. Medicare Eligible? Yes No
☐ Annual ☐ Monthly ☐ Weekly ☐ Insurance Amt				☐ ☐	☐ ☐

21. Dependents - Please list all eligible dependents for which coverage is being requested.

A. (A dependent may be your spouse, your unmarried biological or adopted child, or an unmarried child who depends upon you for support and lives with you in a parent/child relationship.) If the child does not meet this definition, please complete the special dependent form.)

Dependent's Full Name	Social Security Number	Relationship	Biological Adopted Other	Birthdate Mo. Day Yr.	*Other Ins. Coverage Yes No	Medicare Eligible? Yes No	**Full-Time Student Yes No
[redacted]		WIFE	☐ ☐		☐ ☒	☐ ☒	☐ ☒
[redacted]			☐ ☐		☐ ☐	☐ ☐	☐ ☐
		CHILD	☒ ☐		☐ ☒	☐ ☒	☒ ☐
			☐ ☐		☐ ☐	☐ ☐	☐ ☐
			☐ ☐		☐ ☐	☐ ☐	☐ ☐
			☐ ☐		☐ ☐	☐ ☐	☐ ☐

B) Are any of the dependents to be covered medically confined (in a hospital, at home or elsewhere)? ☐ Yes ☐ No. If Yes, please provide the name of the dependent and the reason for confinement:

C) *Other (or Prior) Insurance Coverage - If Yes was checked above in item 21A, or if any listed dependent has had other health coverage at any time during the past 12 months, the information requested in Sections 12-13 above (for the employee) must be provided here for each such dependent. Use Section 22 - Special Remarks - if additional space is required.

D) **Full Time Student - If Yes was checked above in item 21A, please provide the name of the school and anticipated graduation date.

BROOKLYN GLOBAL STUDIES. NEW YORK PUBLIC School System.

22. Special Remarks (Use for further explanations concerning items 1-21)

PRE TAX.

23. ACKNOWLEDGEMENTS - I am presently employed and qualify as an eligible employee according to the terms of my employer's plan of benefits, understand that misstatements, misrepresentations or omissions may result in my insurance coverage being void as of its effective date with no benefit payable, and that any contributory group insurance is not effective until this form is approved by Aetna Life Insurance Co. I hereby request the group insurance coverage for which I am eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

Fraud Warning Notice: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature: [redacted] Date 9/12/95

Employer Signature: [redacted] Date 9-28-95

GR-65872-9 (5-95) CAT. 2000732300 SBM

AETNA COPY

CONFIDENTIAL

MSG 41118

DAVE SHAW
Senior Vice President
Technical Operations

REDACTED

June 25, 2001

[redacted]

Dear [redacted]

As we have discussed, you are hereby discharged by MSG Networks. For salary purposes, your discharge will be effective two weeks from the date of this letter. You will be on paid leave status from now until then and will not be coming to work.

The reason for your discharge is your repeated submission of applications for medical insurance misrepresenting that you were married to [redacted] when you and [redacted] were never married, and your failure to correct such misrepresentation. Your actions caused the company to expend tens of thousands of dollars in payments to insurance companies and the insurance companies to expend unknown amounts in payment of medical claims.

Your actions constituted "dishonesty" and "other just cause" for your dismissal under the MSG Network - Local 1212 Collective Bargaining Agreement ("CBA").

This letter, a copy of which is being sent to Local 1212, constitutes the notice of cause of discharge required under Article II, Section 25 of the CBA.

Sincerely,

David Shaw
MSG Networks

cc: Local 1212

MADISON SQUARE GARDEN NETWORKS
Four Pennsylvania Plaza
New York, NY 10001-2006
Tel 212.465.5965 Fax 212.465.4489

FOX SPORTS NET NEW YORK

CONFIDENTIAL

MSG 41119

Oxford Health Plans

Union 9

REDACTED

Member Enrollment and Physician Selection Form

Mailing Address:
P.O. Box 5031, Norwalk, CT 06856-5031
203-852-1442 · 800-444-6222

Corporate Address:
800 Connecticut Ave., Norwalk, CT 06854

OXFORD USE ONLY DATE: INITIALS: ID NO.:

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER): USG
GROUP NUMBER: 02
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE: MO. DAY 1 YEAR 97
IS INDIVIDUAL COVERED UNDER COBRA? ☐ YES ☒ NO | IF YES, QUALIFYING EVENT | DATE OF QUALIFYING EVENT
PRODUCT SELECTED ☐ HMO ☒ Freedom ☐ Liberty ☐ Liberty HMO ☐ Other:
IS EMPLOYEE CURRENTLY ACTIVELY AT WORK? ☒ YES ☐ NO | ON LEAVE OF ABSENCE? ☐ YES ☒ NO | RETIRED? ☐ YES ☒ NO | AVERAGE NO. OF HOURS WORKED PER WEEK | DATE OF FULL-TIME EMPLOYMENT MO. DAY YEAR
X EMPLOYER SIGNATURE [signature] | DATE MO. 12 DAY 3 YEAR 96 | EMPLOYEE OCCUPATION

To Be Completed By EMPLOYEE (Please Print)

[redacted] ME & MI | APT. NO. | HOME PHONE | BUSINESS PHONE | COUNTY
STATE
OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE
TYPE OF COVERAGE: Family | OTHER HEALTH COVERAGE (INCLUDING MEDICARE)? ☐ YES ☒ NO | IF YES, CARRIER NAME | POLICY NUMBER

EMPLOYEE'S Dependent Information (Please Print)

[redacted] BIRTH DATE | SOCIAL SECURITY NUMBER | ☐ MALE ☐ FEMALE | DATE OF MARRIAGE [illegible]
OTHER HEALTH COVERAGE (INCL. MEDICARE)? ☐ YES ☐ NO | IF YES, NAME OF CARRIER | COVERAGE DATE(S)
SPOUSE'S EMPLOYER | SPOUSE'S OCCUPATION | DAYTIME PHONE (Include Area Code)
SPOUSE'S OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | SPOUSE'S OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE | IS THIS DEPENDENT DISABLED? ☐ YES ☒ NO

[redacted] DATE | SOCIAL SECURITY | ☐ MALE ☐ FEMALE | AGE
OTHER HEALTH COVERAGE (INCL. MEDICARE)? ☐ YES ☒ NO | IF YES, NAME OF CARRIER | COVERAGE DATE(S)
OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE | IS THIS DEPENDENT DISABLED? ☐ YES ☒ NO

ELIGIBLE CHILD'S LAST NAME | FIRST NAME AND MI | BIRTH DATE | SOCIAL SECURITY NUMBER | ☐ MALE ☐ FEMALE | AGE
OTHER HEALTH COVERAGE (INCL. MEDICARE)? ☐ YES ☐ NO | IF YES, NAME OF CARRIER | POLICY NUMBER | COVERAGE DATE(S)
OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE | IS THIS DEPENDENT DISABLED? ☐ YES ☐ NO

ELIGIBLE CHILD'S LAST NAME | FIRST NAME AND MI | BIRTH DATE | SOCIAL SECURITY NUMBER | ☐ MALE ☐ FEMALE | AGE
OTHER HEALTH COVERAGE (INCL. MEDICARE)? ☐ YES ☐ NO | IF YES, NAME OF CARRIER | POLICY NUMBER | COVERAGE DATE(S)
OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE | IS THIS DEPENDENT DISABLED? ☐ YES ☐ NO

ELIGIBLE CHILD'S LAST NAME | FIRST NAME AND MI | BIRTH DATE | SOCIAL SECURITY NUMBER | ☐ MALE ☐ FEMALE | AGE
OTHER HEALTH COVERAGE (INCL. MEDICARE)? ☐ YES ☐ NO | IF YES, NAME OF CARRIER | POLICY NUMBER | COVERAGE DATE(S)
OXFORD PRIMARY CARE PHYSICIAN | OXFORD CODE | OXFORD OB/GYN (Female Members) | OXFORD OB/GYN CODE | IS THIS DEPENDENT DISABLED? ☐ YES ☐ NO

If you have additional dependents, please use another enrollment form to provide the necessary information. In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

HMO AGREEMENT I understand that my enrollment and benefits are in accordance with those described in the applicable Oxford Health Plans HMO Certificate. I understand that, in order to qualify for HMO benefits, I and any enrolled dependents must choose an Oxford-affiliated Physician for primary care and secure a referral from that Physician to an Oxford affiliated Physician for specialist care. I authorize any health provider or insurer to furnish Oxford Health Plans any records concerning me or any enrolled member of my family for whom information is requested. A photographic copy of this authorization shall be valid as the original.

OUT-OF-NETWORK AGREEMENT (if applicable): I understand that in addition to the applicable Oxford Health Plans HMO Certificate, my enrollment and benefits are in accordance with those described in the Oxford Health Plans Member Certificate and Handbook. I understand that I will be eligible only for traditional health insurance coverage under the terms of the Oxford Health Plans Member [redacted]

EMPLOYEE/APPLICANT SIGNATURE | DATE 12/24/96

OHP-333 10/95 | WHITE COPY: OXFORD | PINK COPY: OFFICE | YELLOW COPY: EMPLOYER | GREEN COPY: EMPLOYEE/MEMBER

CONFIDENTIAL

Employer/Employee Copy

PLEASE PRINT YOUR CHARACTERS CAREFULLY AND USE ONLY CAPITAL LETTERS AS SHOWN.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7 8 9

DO NOT USE RED INK OR RED PENCIL

66666

1 EMPLOYEE INFORMATION

EMPLOYEE LAST NAME [redacted] FIRST NAME [redacted] M.I.

STREET NUMBER AND STREET NAME (COMPLETE ADDRESS)

CITY STATE ZIP

DAYTIME PHONE NUMBER

SOCIAL SECURITY NUMBER REDACTED

2 PLAN OPTION

SELECT ONLY ONE

[X] DMO PLAN - I WISH TO ENROLL IN THE DMO.
IF YOU CHOOSE THIS PLAN, YOU MUST ALSO ENTER A DMO DENTIST OFFICE ID FOR EACH PERSON COVERED.

[X] TRADITIONAL PLAN - I REQUEST COVERAGE IN THE TRADITIONAL PLAN.
IF YOU CHOOSE A TRADITIONAL PLAN, DO NOT ENTER A DMO DENTIST OFFICE ID FOR ANY PERSON COVERED.

3 FAMILY INFORMATION AND DMO DENTIST SELECTION

INCLUDING YOURSELF, LIST THE FIRST NAME OF EACH FAMILY MEMBER TO BE COVERED. WRITE THEIR LAST NAME ONLY IF IT DIFFERS FROM YOURS. IF YOU HAVE MORE THAN FOUR CHILDREN, PLEASE USE SECTION 4.

		SEX M or F	CHECK BOX IF FULL-TIME STUDENT AND 19 OR OLDER. WRITE SCHOOL NAME(S) IN SECTION 4.	DATE OF BIRTH	CHECK BOX IF CHILD IS 19 OR OLDER AND DISABLED.	IF YOU CHOOSE THE DMO PLAN, COMPLETE THIS PORTION. DMO DENTIST OFFICE ID
EMPLOYEE	[redacted]			/ /		
SPOUSE	[redacted]			/ /		
CHILD 1	[redacted]			/ /		
CHILD 2			X	M M D D Y Y	X	
CHILD 3			X	M M D D Y Y	X	
CHILD 4			X	M M D D Y Y	X	

4 ADDITIONAL INFORMATION

5 EMPLOYEE AUTHORIZATION

I AUTHORIZE MY EMPLOYER TO WITHHOLD MY CONTRIBUTION, IF ANY, FROM MY PAYCHECK. I DIRECT PRUDENTIAL TO PAY BENEFITS THAT BECOME DUE UNDER THE DMO TO THE PROVIDER OF SERVICES AND AGREE THE PROVIDER MAY RELEASE ALL NECESSARY TREATMENT RECORDS TO PRUDENTIAL.

[redacted] DATE

COMPANY NAME (EMPLOYER)

FOR EMPLOYER USE ONLY

CONTROL NUMBER

EFFECTIVE DATE OF SELECTED COVERAGE M M D D Y Y

BRANCH

DATE FIRST COVERED UNDER TRADITIONAL PLAN M M D D Y Y

MSG 41121

CONFIDENTIAL

Hausner, Marilyn

From: Shaw, David
Sent: Tuesday, April 10, 2001 9:12 AM
To: Hausner, Marilyn
Subject: FW: [redacted]

Sensitivity: Confidential

FYI. I actually saw the tail end of this conversation [redacted] was having with Madeline, which was an attempt on his part to have Madeline keep the call from his "ex" from reaching me. He told me that his "ex" may be calling me to tell me that [redacted] falsified information on his application, and then he began to explain to me that all was proper on his application, "...as you recall, Dave, when I was hired..." I told him I was not at all involved in his hire, since I wasn't in management at the time.

Do you think his application should be looked at?

Dave

-----Original Message-----
From: Sica, Madeline
Sent: Monday, April 09, 2001 5:59 PM
To: Shaw, David
Cc: Sica, Madeline
Subject: [redacted]

FYI -

I had a conversation on 4/2 at 11:55am with [redacted] a notation is made in your phone log). [redacted] came to the office to "give me a heads up" that you might receive a phone call from his ex-girlfriend [redacted] He said she might call and tell you things like he falsified information on his work application. He explained she has a history of mental problems and substance abuse.

[redacted] saw me the next day (4/3) in the tech area posting an MSG schedule update. He informed me [redacted] called his current girlfriend and said she wouldn't call MSG with any slanderous (exact word) statements about [redacted] I thanked him for the update and told him she hasn't called as of yet.

Madeline

Hausner, Marilyn

-----Original Message-----
From: Shaw, David
Sent: Tuesday, April 10, 2001 9:12 AM
To: Hausner, Marilyn
Subject: FW: [redacted]
Sensitivity: Confidential

FYI. I actually saw the tail end of this conversation [redacted] was having with Madeline, which was an attempt on his part to have Madeline keep the call from his "ex" from reaching me. He told me that his "ex" may be calling me to tell me that [redacted] falsified information on his application, and then he began to explain to me that all was proper on his application, "...as you recall, Dave, when I was hired..." I told him I was not at all involved in his hire, since I wasn't in management at the time.

Do you think his application should be looked at?

Dave

-----Original Message-----
From: Sica, Madeline
Sent: Monday, April 09, 2001 5:59 PM
To: Shaw, David
Cc: Sica, Madeline
Subject: [redacted]

REDACTED

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him for the update and told him she hasn't called as of yet.

Madeline

Hausner, Marilyn

-----Original Message-----
From: Hausner, Marilyn
Sent: Wednesday, May 23, 2001 11:57 AM
To: Kaye, Aimee
Subject: [redacted]

[redacted]

Aimee
As we discussed, attached is a memo summarizing the issue regarding [redacted] with a recommendation for termination.

Marilyn

REDACTED

Hausner, Marilyn

-----Original Message-----
From: Hausner, Marilyn
Sent: Wednesday, May 23, 2001 11:57 AM
To: Kaye, Aimee
Subject: [redacted]

Aimee
As we discussed, attached is a memo summarizing the issue regarding [redacted] with a recommendation for termination.

Marilyn

REDACTED