

## ARTRA 524(g) Asbestos Trust Claim Form

### General Instructions for filing this Claim Form:

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; *submitting an incomplete form may result in delays in processing, and/or the Trust may not be able to assign the claim a position in the FIFO processing queue.* Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the Review election that best suits the injured party's situation:

Expedited     
  Individualized     
  Extraordinary     
  Secondary Exposure

If electing Exigent treatment, check here:  Exigent Health       Exigent Hardship

Section 1: Injured Party Information			Firm's Matter # for this claim:	
Last Name	First Name	Middle Name	Suffix	
Social Security Number  _ - - - -	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Death (mm/dd/yyyy)	Was death asbestos related? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if not represented by counsel)				
City	State	ZIP Code	Daytime Telephone	

### Section 2: Law Firm / Attorney Information

*If the injured party is represented by counsel, please provide the following information:*

Law Firm Name			Filer ID	
Mailing Address				
City			State	ZIP Code
Attorney Last Name	Attorney First Name	Attorney Middle Name	Suffix	
Direct Telephone	Facsimile	Email Address		

### Section 3: Asbestos Related Injury

*Check the box next to the highest Disease Level the injured party is claiming.*

Disease Level	
<input type="checkbox"/> Other Asbestos Disease (Level I)	<input type="checkbox"/> Asbestosis/Pleural Disease (Level II) <input type="checkbox"/> Severe Asbestosis (Level III)
<input type="checkbox"/> Other Cancer (Level IV)	<input type="checkbox"/> Lung Cancer (Level V) <input type="checkbox"/> Mesothelioma (Level VI)
Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level IV), please specify malignancy:

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 4: Smoking History (Not Required for Expedited Review)**

*In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of packs and/or cigars smoked per day. Indicate fractional packs and/or cigars as decimals (e.g. enter 1/2 pack per day as 0.5)*

Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day

**Section 5: Personal Representative (if injured party is deceased or incompetent)**

Last Name	First Name	Middle Name	Suffix
Capacity of Personal Representative (i.e. Administrator, Executor, Guardian, etc.)			
Mailing Address (If injured party is not represented by counsel)			
City	State	ZIP Code	Daytime Telephone

**Section 6: Asbestos Litigation**

If an asbestos-related lawsuit has ever been filed on behalf of the injured party, provide the following information:

File Date (mm/dd/yyyy)	State	Court
Docket Number		ARTRA Named? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has injured party received settlement monies related to this lawsuit from ARTRA or its insurers? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes", Amount:
If no lawsuit has ever been filed against ARTRA Entities on behalf of the injured party, indicate in which state the claimant would have elected to file such suit:		State
Is the claimant a holder of a Muralo Contract Claim as defined in Section 2.7 of the TDP? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 7: Occupational Exposure to Asbestos Products**

Provide the information below in order to satisfy the requirements ARTRA Exposure and Significant Occupational Exposure, as set forth in sections 5.7 (b)(3) and 5.7(b)(2) of the TDP. Do not list multiple occupations or date ranges for each exposure site – if an injured party worked at the same site in two or more occupations, or during two or more periods, please complete a separate line. Please refer to the Filing Instructions for details on the Exposure Criteria for each Disease Level. *Attach additional copies of this page if more space is required.*

**Exposure Site 1**

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State
Country		Country	
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
ARTRA products used at this Site:			
<p>Significant Occupational Exposure : If the claimant's occupation and industry appears on the list of Presumed SOE Occupation &amp; Industry Pairings (available at <a href="http://www.artratrust.com">www.artratrust.com</a>), please indicate the circumstances of exposure to asbestos and/or asbestos containing products by checking one or more of the descriptions below.</p> <p><input type="checkbox"/> Claimant handled raw asbestos fibers on a regular basis</p> <p><input type="checkbox"/> Claimant fabricated asbestos-containing products such that the claimant in the fabrication process was exposed on a regular basis to asbestos fibers</p> <p><input type="checkbox"/> Claimant altered, repaired or otherwise worked with an asbestos-containing product such that the claimant was exposed on a regular basis to asbestos fibers</p> <p><input type="checkbox"/> Claimant was employed in an industry or occupation such that the claimant worked on a regular basis in close proximity to workers who did one or more of the above three activities</p> <p><input type="checkbox"/> Other (Please describe in as much detail as possible):</p> <p>If the claimant's occupation and industry <b>does not</b> appear on the list of Presumed SOE Occupation &amp; Industry Pairings, please provide a description of how the claimant was exposed to asbestos and/or asbestos containing products in the space below:</p>			

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 7 (cont'd): Occupational Exposure to Asbestos Products**

**Extraordinary Claims**

If the claimant is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claimant satisfies Section 5.4(a) of the TDP:

**Section 8: Secondary Exposure (*Not Required for Expedited Review*)**

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person, complete Section 7, Part 1 with the exposure information for the occupationally exposed person, and provide the information below:

Date Exposure to Other Person Began (mm/dd/yyyy)	Date Exposure to Other Person Ended (mm/dd/yyyy)	Relationship to Occupationally Exposed Person
Description of how injured party was exposed to ARTRA Products:		

**Section 9: Employment / Earnings information (*Not Required for Expedited Review*)**

If economic losses are being claimed, you must enclose an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Partially Disabled <input type="checkbox"/> Fully Disabled <input type="checkbox"/> N/A (Deceased)	
Amount of Last Annual Wages	Date of Last Wage Received (mm/dd/yyyy)

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 10: Dependents (Not Required for Expedited Review)**

List the injured party's spouse and any other dependents.

**Dependent 1**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dependent 2**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dependent 3**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dependent 4**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dependent 5**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Dependent 6**

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 11: Certification and Signature**

*This claim form must be signed by the claimant's attorney, or if not represented by an attorney, the claimant or his/her personal representative.*

I have reviewed the information provided on this claim form, and all documents submitted in support of this claim. I hereby certify that this information is accurate and complete to the best of my knowledge, information and belief, and that all available documentation has been provided as required by the Trust Distribution Procedures, including but not limited to all medical reports required by Sections 5.7(a) therein.

Signed	Date Signed
--------	-------------

Print Name Here
-----------------

**To file by mail, send this completed form and all supporting documentation to:**

ARTRA 524(g) Asbestos Trust  
c/o Verus Claims Services, LLC  
57 Hamilton Avenue, Suite 208  
Hopewell, NJ 08525

**ARTRA 524(g) Asbestos Trust  
Claim Form**

**Section 12: Checklist of Supporting Documentation**

**Please attach the following supporting documentation to the completed claim form:**

*For all claimants:*

- Medical records supporting the diagnosis of the claimed Disease Level (see Instructions for requirements)
- Proof of ARTRA product exposure, as set forth in the detailed Filing Instructions

*For deceased claimants:*

- Death certificate
- Letters of Administration or other proof of personal representative's official capacity, if applicable pursuant to state law

*For Exigent Hardship Claims and/or claimants asserting a claim for Lost Wages:*

- Documentation supporting the claim that any and all wage loss incurred by the injured party was the direct result of injured party's asbestos-related disease. This documentation would include, but not be limited to medical records and/or reports, reports from governmental or insurance agencies and/or reports from claimant's most recent employer.
- Tax returns and/or W-2 forms for the last three (3) full years of employment.