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	Date of Death (mm/dd/yyyy)	Was death asbestos related?
_____-____-_____		☐Male ☐Female		☐ Yes ☐ 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

☐ Other Asbestos Disease (Level I) ☐ Asbestosis/Pleural Disease (Level II) ☐ Severe Asbestosis (Level III)

☐ Other Cancer (Level IV) ☐ Lung Cancer (Level V) ☐ Mesothelioma (Level VI)

Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level IV), please specify malignancy:

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 ½ pack per day as 0.5)

Product	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			

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?
	☐ Yes ☐ No

Has injured party received settlement monies related to this lawsuit from ARTRA or its insurers?	If "yes", Amount:
☐ Yes ☐ No	

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? ☐ Yes ☐ No

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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
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify			
ARTRA products used at this Site:					

Significant Occupational Exposure : If the claimant's occupation and industry appears on the list of Presumed SOE Occupation & Industry Pairings (available at www.artratrust.com), please indicate the circumstances of exposure to asbestos and/or asbestos containing products by checking one or more of the descriptions below.

☐ Claimant handled raw asbestos fibers on a regular basis

☐ Claimant fabricated asbestos-containing products such that the claimant in the fabrication process was exposed on a regular basis to asbestos fibers

☐ Claimant altered, repaired or otherwise worked with an asbestos-containing product such that the claimant was exposed on a regular basis to asbestos fibers

☐ 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

☐ Other (Please describe in as much detail as possible):

If the claimant's occupation and industry ***does not*** appear on the list of Presumed SOE Occupation & Industry Pairings, please provide a description of how the claimant was exposed to asbestos and/or asbestos containing products in the space below:

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)	
☐ Full-time ☐ Part-time ☐ Retired ☐ Partially Disabled ☐ Fully Disabled ☐ N/A (Deceased)	
Amount of Last Annual Wages	Date of Last Wage Received (mm/dd/yyyy)

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? ☐ Yes ☐ No	

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	

Dependent 5

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	

Dependent 6

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	

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
3967 Princeton Pike
Princeton, New Jersey 08540

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.