EXHIBIT
A

F01002-1

PROOF OF MANUFACTURER FORM

FOR DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.1)

Use this form to submit medical records or documents that show that you were implanted with a Dow Corning breast implant.

1. Use the peel-off label provided in your packet.

2745881

AFFIX YOUR LABEL HERE

PROVIDE UPDATES OR CORRECTIONS BELOW:

1. Claim Number or Social Security Number: ___-__-____
2. Date of Birth: __/__/__ Mon/Date/Year
3. New Last Name
4. New Address

City State Zip Code

5. Daytime Phone: (___) ___
6. Evening Phone: (___) ___
7. Attorney's Name/Address/Phone/Fax:
8. If you want to receive newsletters or information about your claim by e-mail, provide your e-mail address:

2. Check either Box 2A or 2B below. Read the attached Instructions and Section 5 in the Claimant Information Guide for more information.

2A. ☑ I am attaching to this form copies of my medical records or documents that show that I was implanted with a Dow Corning breast implant. *(Please keep a copy for your file.)*

OR

2B. ☐ I have already submitted my medical records or documents that show that I was implanted with a Dow Corning breast implant, and I am not attaching any additional records or documents. *(You do not need to resubmit your medical records or documents, however, submitting another copy may speed up the review of your claim.)*

PROOF OF MANUFACTURER FORM

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3. Complete the following chart to provide information about all of the breast implant(s) you have received. If additional space is needed, use a blank piece of paper, and clearly print your name and Social Security Number or Claim Number on each piece of paper.

Date of Breast Implant Surgery	Brand Name or Name of Implant Manufacturer	Country Where You Were Implanted & Name of Physician	Date Implant Was Removed
____/____/____ (Month /Day/Year)			☐ Removed ___/___/___ (Month /Day/Year) ☐ Not Removed
____/____/____ (Month /Day/Year)			☐ Removed ___/___/___ (Month /Day/Year) ☐ Not Removed
____/____/____ (Month /Day/Year)			☐ Removed ___/___/___ (Month /Day/Year) ☐ Not Removed
____/____/____ (Month /Day/Year)			☐ Removed ___/___/___ (Month /Day/Year) ☐ Not Removed
____/____/____ (Month /Day/Year)			☐ Removed ___/___/___ (Month /Day/Year) ☐ Not Removed

4. Sign the Proof of Manufacturer Form below.

I declare under penalty of perjury that I was implanted with a Dow Corning breast implant, and that the information on this form is true, correct and complete to the best of my knowledge, information and belief.

2021 12 20
Date Signed

Signature of Claimant, Executor/Administrator, or Guardian

F01005-1

$1,200 (U.S.) EXPEDITED RELEASE PAYMENT OR DISEASE PAYMENT CLAIM FORM

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.1)

Use this form to apply for either the $1,200 (U.S.) Expedited Release Payment *OR* a Disease Payment ranging from $7,200 - $180,000 (U.S.).

1. Use the peel-off label provided in your packet.

2745881

AFFIX YOUR LABEL HERE

PROVIDE UPDATES OR CORRECTIONS BELOW:

1. Claim Number or Social Security Number: ___-___-____ 2. Date of Birth: ___/___/___ Mon /Date/Year
3. New Last Name
4. New Address

City State Zip Code

5. Daytime Phone: (___) ___
6. Evening Phone: (___) ___
7. Attorney's Name/Address/Phone/Fax:
8. If you want to receive newsletters or information about your claim by e-mail, provide your e-mail address:

2. Check Box 2A to apply for the $1,200 (U.S.) Expedited Release Payment or Box 2B to apply for the Disease Payment. Do not check both boxes.

2A. ☐ I am making a claim for the $1,200 (U.S.) Expedited Release Payment. I understand that I am giving up my right to apply for the Disease Payment now or in the future. The deadline to apply for this payment is three (3) years from the Effective Date. *(If you check this box, skip to Question 6 and sign the form.)*

OR

2B. ☑ I am making a claim for a Disease Payment. I have obtained all of the medical records and documents required to support my claim, and I am ready to have my disease claim evaluated. The deadline to apply for this payment is fifteen (15) years from the Effective Date. *(If you check this box, proceed to Question 3.)*

♦ $1,200 (U.S.) EXPEDITED RELEASE PAYMENT OR DISEASE PAYMENT CLAIM FORM ♦

3. ☐ *Check this box only if your disease claim was evaluated in the Foreign or Revised Settlement Program (FSP or RSP) **and** you intend to rely on that existing evaluation without submitting any additional medical records or documents. If this is the case, skip to Question 6 and sign the form. However, if you want to apply for a disease or disability/severity level that is different than what your disease claim was approved in the FRSP, then proceed to Question 4.*

4. *Choose only one (1) of the diseases or conditions below in 4A - 4I. If you check more than one (1) of these boxes, the Settlement Facility will not process your disease claim until you choose only one (1).*

4A. ☑ I am making a claim for Atypical Connective Tissue Disease (ACTD), also called Atypical Rheumatic Syndrome (ARS) or Non-Specific Autoimmune Condition (NAC).

or

4B. ☐ I am making a claim for Atypical Neurological Disease Syndrome (ANDS).

or

4C. ☐ I am making a claim for Primary Sjogren's Syndrome (PSS).

or

4D. ☐ I am making a claim for Mixed Connective Tissue Disease/Overlap Syndrome (MCTD).

or

4E. ☐ I am making a claim for Systemic Sclerosis /Scleroderma (SS).

or

4F. ☐ I am making a claim for Systemic Lupus Erythematosus (SLE).

or

4G. ☐ I am making a claim for Polymyositis (PM).

or

4H. ☐ I am making a claim for Dermatomyositis (DM).

or

4I. ☐ I am making a claim for General Connective Tissue Symptoms (GCTS).

If you do not qualify for the disease or condition that you checked in Question 4C-4I, the Settlement Facility will evaluate your disease claim to determine if you qualify for Atypical Connective Tissue Disease (ACTD) and/or Atypical Neurological Disease Syndrome (ANDS).

5. *Please check either Box 5A or 5B below:*

5A. ☑ Attached to this form are new or additional medical records that support my disease claim. *(Please keep a copy for your file.)*

5B. ☐ I have already submitted medical records and documents that support my disease claim, and I do not have any additional records to submit.

6. *Sign the form below. If you are applying for the Expedited Release Payment, you must sign and return this form on or before three (3) years after the Effective Date.*

If you are applying for a Disease Payment, you must sign and return this form along with medical records on or before fifteen (15) years after the Effective Date.

I declare under penalty of perjury that the information for this claim is true, correct and complete to the best of my knowledge, information and belief.

2021 12. 20
Date Signed

Jkonkokim
Signature of Claimant, Executor/Administrator, or Guardian

시술 제품 확인서

성 명 : 김재희
주민번호 : 590812 - 2001511
주 소 : 서울시 마포구 성산동 140-2

상기인은 본원에서 1990.9.6. 가슴에 실리콘을 삽입하는 수술을 시술 받았으며 당시 사용한 시술제품은 다우코닝사 제품이었음을 확인함

* 근거 : 당시 수술차트 등 병원기록은 10년의 보관기간이 지났으므로 폐기 처분하였음

하지만 본 병원에서는 위 수술을 시행할 당시 다우코닝사 제품만을 사용하였으므로 상기인에 대한 시술제품은 다우코닝 제품으로 확인 가능함

2005. / . .

발 급 자 : 성형외과전문의 이태권 (또는 의사 인)
의사번호 : 제 7857 호 전문의번호 62
주 소 : 서울 서초구 반포동 706-8
(이태권 성형외과)

YONG PARK, MD., PHD.
Neurologist/Surgeon
128-33 Sangbong-Dong, Joongryang-Ku, Seoul, Korea T:02-493-7877

Patient's Name: Jae Hee Kim
Social Security Number: 590812-2001511
Date: October 27, 1994

I have conducted a review and re-evaluation of the above patient and make the following observation in my report:

1. The above patient is an honest and credible patient.

2. My evaluation is not based solely on her subjective complaints, but rather is predicated upon my own findings and opinion regarding my objective determination of her physical condition at the time of my initial examination of her.

3. Personal history is an important aspect of the assessment necessary to render a disability and impairment rating, although I have made a specific effort to corroborate her complaints of pain and functional limitations.

4. My assessment of the patient and my determination of her disability concerned an evaluation of the severity of her pain and the apparent and probable limitations on her vocational, avocational, and personal life.

5. Date of onset of disability always presents a challenge in the rendering of a specific point of beginning. The following year of her surgery, she began having physical problems which significantly interfered with her work and personal life. This provides the best indicator of the date that her symptoms and disability coalesced.

6. The diagnosis that I reached and the degree of disability that I assigned to this patient was based upon the Medical Conditions and Characteristics Outline of Definitions and Classification Criteria found in the breast implant litigation settlement agreement.

7. At her request, she was seen for evaluation of possible problems associated with the use of breast implants. In addition to reviewing all records concerning the breast surgery which she had, I conducted an extensive physical examination and took a detailed history from her.

8. My report covers the most important aspects of the history, physical examination, and records reviewed, but does not cover everything that I discussed with the patient.

9. The degree of disability that I assigned to this patient was based upon a comparison of her pre-implant condition to her present status. I also considered the roles of aging and other factors not associated with the criteria in making this evaluation.

MEDICAL HISTORY

This patient is 35 year old, Asian female who received silicone implants in 1990. Since then she has demonstrated loss of functional capacity which renders her unable to perform some of her activities of usual vocation, avocation, and self-care, or she can only perform them with regular or recurring moderate pain.

She has undergone mammogram, thermography, and blood test, and on examination today, she shows tingling sensations in the extremities, polyarthritis on multi-joints, and muscle weakeness. Her breasts are hard with granulomas and painful on a slightest touch. She has difficulty in remembering anything.

NEUROLOGICAL AND MUSCULOSKELETAL EVALUATION

This patient reports widespread pain, arthralgia on her neck, Myalgias on the left leg, chronic fatigue, anxiety, sleep disorders and other multiple symptoms. The patient suffers from moderate Fibrocystic disease of the breasts which began after the silicone implant surgery.

As time went on, the pain affected the chest, shoulder, back, hands, ankles, and feet. She had developed increasing pain affecting the breast/chest wall region and the shoulder. Unfortunately, the patient has had increasing difficulty in her normal activities since the implant surgery.

While she also has significant pain affecting the shoulder and chest region, she is able to use arms fairly well and the pain is much less as compared to the chest and shoulder pain. However, she often guards them against use for most activities and she tells me that she has not had any therapy for this particular pain.

In addition, she has had diabling fatigue for the last several months. Other problems include numbness involving her feet, which tends to be worse in the morning, dry mouth, and difficulty with with memory and concentration.

She has noted occasional problems with her balance and she will tend to stumble. She has had difficulty with sleep including frequent awakenings and non-restorative sleep pattern. Over the last year or so, she notes that she has been bruising easily. She reports cold hands and feet for the last year.

She has a history of recurrent headaches of the migraine type for last year, but occurring perhaps more frequently at this time. They tend to be throbbing or dull. She also reports problems with her bladder function. She has had a history of depression in the past.

Her typical pain level is a 6 on a 0-to-10 scale, and her disability level is 20%.

IMPRESSION

1. Atypical Connective Tissue Disease associated with silicone gel implants. This patient meets the criteria set forth in the medical conditions and characteristics outline of definitions and classification criteria found in the breast implant litigation settlement agreement. She would fit into Disability Category C as she clearly is disabled in that she demonstrates functional capacity adequate to consistently perform some of the usual duties or activities of vocation, avocation, or self-care. She met the criteria for this degree of disability.

2. Fybromyalgia. The patient meets the American College of Rheumatology's criteria for Fibromyalgia. It would be useful to set up a program for treatment which has been shown to be helpful in Fibromyalgia. These are multifaceted, polymodal programs involving pharmacotherapy, appropriate physical therapy, stress relaxation/counseling, etc.

3. Prominent dysfunction of the arm and the shoulder. While there are significant trigger points involved in this region, the pain and movement dysfunction is moderate that other intrinsic pathology of the shoulder cannot be ruled out. In addition, this clearly is evolving into a frozen shoulder syndrome due to lack of use. This needs to be addressed, both from a diagnostic standpoint and from a therapeutic standpoint

COMPENSATION CATEGORY: C
AGE OF ONSET SYMPTOMS: 31
AGE OF ONSET DISABILITY: 32

The above is my opinion within a reasonable degree of medical certainty based upon information supplied by the patient and based upon reference to Disease Schedule, Schedule D.

Yong Park, Md.

PHYSICAL EXAMINATION Date: 10-27-1994

Patient Name: Jae Hee Kim Soc Sec No: 590812-2001511

Check on 1st col. for PERTINENT PHYSICAL FINDINGS (Documented)
Check on 2nd col. for PERTINENT SYMPTOMS

✓	✓	1. Polyarthralgias
		2. Polymyalgias on palpitation
✓	✓	3. Chronic fatigue
		4. Lymphadenopathy
✓	✓	5. Cognitive dysfunction or paresthesias
	✓	6. Photosensitivity
✓	✓	7. Sicca symptoms
		8. Dysphagia
✓	✓	9. Alopecia
✓	✓	10. Balance distubances
✓	✓	11. Sleep disturbances
✓		12. Easy bruising or bleeding disorder
✓	✓	13. Chronic cystitis or bladder irritability
		14. Colitis or bowel irritability
✓	✓	15. Low grade fever or night sweats
	✓	16. Mucosal ulcers
✓	✓	17. Burning pain in the chest+, breast+, arms+, subsbtantial loss of function in the breast due to disfigurement or other complications from implants or explantation

DISABILITY LEVEL 20%

Many activities can not be done or if done with severe ____
moderate pain. ✓

RCyr

Signature by attending Physician

ATYPICAL CONNECTIVE TISSUE DISEASE/ ATYPICAL RHEUMATIC SYNDROME/ NON-SPECIFIC AUTOIMMUNE CONDITION

A DIAGNOSIS OF ATYPICAL CONNECTIVE TISSUE DISEASE OR ATYPICAL RHEUMATIC SYNDROME OR NON-SPECIFIC AUTOIMMUNE CONDITION REQUIRES ONE OF THE FOLLOWING GROUPS OF FINDINGS:

_____1. One of the signs or symptoms listed in paragraph A and one from paragraph B... OR:

_____2. Three signs or symptoms from Paragraph B... OR:

_____3. Two Signs or symptoms from Paragraph A... OR:

_____4. Two signs or symptoms from Paragraph B plus one non-duplicative sign or symptom from Paragraph C... OR:

_____5. A total of five non-duplicative signs or symptoms from any of the Paragraphs A through C.

SYMPTOM GROUPINGS:

Paragraph A:

_____1. Raynaud's phenomenon evidenced by the patient giving a history of two color changes, or visual evidence of vasospasm, or evidence of digital ulceration.

_____2. Polyarthritis (swelling and tenderness in three or more joints for at least 6 weeks and MD documented.)

_____3. Keratoconjunctivitis Sicca: c/o dry eyes and/or dry mouth with one of the following:

___a. lacrimal or salivary enlargement
___b. parotid enlargement
___c. abnormal schirmer test
___d. abnormal rose bengal staining
___e. filamentous keratitis
___f. abnormal parotid scan or ultrasound
___g. abnormal CT or MRI of parotid; or
___h. abnormal labial salivary biopsy.

Paragraph B:

_____1. Myalgias determined by tenderness on exam

_____2. Immune mediated skin changes or rash as follows:

___a. changes in texture or rashes that may or may not be characteristic of SLE, Systemic Sclerosis (scleroderma), or dermatomyositis;

___b. diffuse petechiae, telangiectasias, or livedo retic.

_____3. Pulmonary symptoms or abnormalities, which may or may not be characteristic of SLE, Systemic Sclerosis (scleroderma), or Sjogren's Syndrome, as follows:

___a. pleural and/or interstitial lung disease
___b. restrictive lung disease
___c. obstructive lung disease as per clinical findings and:
___ characteristic chest X-ray changes; OR
___ characteristic PFT changes in a non-smoker

_____4. Pericarditis by clinical findings and EKG or Echo

_____5. Neuropsychiatric symptoms: cognitive dysfunction (memory loss and/or difficulty concentrating) which may be characteristic of SLE or MCTD as determined by a SPECT scan or PET scan or MRI or EEG or neuropsychological testing.

_____6. Peripheral neuropathy: by physical exam showing at least one of the following:

___a. ___ loss of sensation to pinprick or vibration or touch or position.
___b. tingling, parasthesias, or burning pain in the extremities.
___c. loss of tendon reflex
___d. proximal or distal muscle weakness (decreased strength in extremities or foot drop)
___e. signs of dysesthesias
___f. entrapment neuropathies

_____7. Myositis or myopathy

___a. diagnosed by muscle weakness on physical exam or by muscle strength testing
___b. abnormal CPK or aldolase
___c. abnormal cybex testing
___d. abnormal muscle biopsy

_____8. Serologic abnormalities:

___a. ANA 1:40 or greater using HEP 2 method
___b. Positive Anti-DNA, SSA(Ro), SSB(La), RNP, SM, Scl-70, centromere, Jo-1, PM-Sci or dsDNA
___c. other autoantibodies: thyroid, anti-microsomal, anti-cardiolipin, or RF (by nephelometry)
___d. elevation of immunoglobin (IgG, IgA, IgM), or
___e. elevated ESR or CRP

_____9. Lymphadenopathy (at least one node, 1 x 1 cm PER MD)

_____10. Dysphagia with positive diagnostics; esophagram, ex.

Paragraph C:

_____1. Documented arthralgias

_____2. Documented Myalgias

_____3. Chronic fatigue (over 6 months)

_____4. Documented lymphadenopathy

_____5. Documented neurological symptoms such as cognitive dysfunction or paresthesias

_____6. Photosensitivity

_____7. Documented Sicca symptoms

_____8. Documented dysphagia

_____9. Documented alopecia

_____10. Documented balance disturbances

_____11. Documented sleep disturbances

_____12. Documented easy bruising or bleeding disorder

_____13. Documented chronic cystitis or bladder irritability

_____14. Documented colitis or bowel irritability

_____15. Persistent low grade fever or night sweats

_____16. Mucosal ulcers confirmed by MD

_____17. Burning pain in the chest, breast, arms or axilla or substantial loss of function in breast due to disfigurement or other complications from implants or explanation.

_____18. Pathological findings: granulomas or siliconomas or chronic inflammatory response, or breast infections

S F D C T

SETTLEMENT FACILITY

DOW CORNING TRUST

P.O. Box 52429
Houston, Texas 77052

Telephone 713.874.6099
866.874.6099

April 25, 2022

SID: 2745881

KIM YEON-HO INTL LAW OFFICES
STE 4105 KOREA WORLD TRADE CTR BLDG
139-1 SAMSUNG-DONG KANGNAM-KU
SEOUL
KOREA, REPUBLIC OF

Claimant: JAE-HEE KIM
Subject: URGENT MESSAGE – YOUR CLAIM CANNOT BE PROCESSED OR PAID BECAUSE WE DO NOT HAVE A VALID ADDRESS

Dear Claimant:

The Settlement Facility-Dow Corning Trust (SF-DCT) needs you to verify your address. We have received information that shows that the address on file may have changed. We are sending you this letter so that you can verify your address.

We cannot process or pay your claim until you confirm your current, valid address and contact information.

To make sure your claim is processed without delay, you must provide your current address information by within six months from the date of this letter. You can provide your address and contact information in any one of the following ways.
:

1. Provide your current address and the last four digits of your social security number (if you have a social security number.) on the attached Address Update/ Correction Form and mail the form to: SF-DCT, P.O. Box 52429, Houston, TX 77052.
2. Contact the SF-DCT by telephone (toll-free) 866-874-6099. Remember to have your SID number available when you call. The SID number appears at the top of this letter.
3. Contact the SF-DCT by electronic mail. You can send an email to info@sfdct.com. You must include the SID number in your email. The SID number appears at the top of this letter. .

If the claimant listed above is deceased, the SFDCT cannot process or pay the claim unless the SFDCT receives: 1. An original death certificate for the claimant; 2. Estate Documentation identifying the person who has been appointed as executor or personal representative with authority to act on behalf of the estate of the claimant; and 3. The address and contact information of the authorized estate representative.

Settlement Facility - Dow Corning Trust

Enclosure: Address Update/Correction Form
CC: JAE-HEE KIM

S F D C T

SETTLEMENT FACILITY
DOW CORNING TRUST

P.O. Box 52429
Houston, Texas 77052

Telephone 713.874.6099
866.874.6099

June 13, 2022

SID: 2745881

KIM YEON-HO INTL LAW OFFICES
STE 4105 KOREA WORLD TRADE CTR BLDG
139-1 SAMSUNG-DONG KANGNAM-KU
SEOUL
KOREA, REPUBLIC OF

Claimant: JAE-HEE KIM
Subject: URGENT MESSAGE – YOUR CLAIM CANNOT BE PROCESSED OR PAID BECAUSE WE DO NOT HAVE A VALID ADDRESS

Dear Claimant:

The Settlement Facility-Dow Corning Trust (SF-DCT) needs you to verify your address. We have received information that shows that the address on file may have changed. We are sending you this letter so that you can verify your address.

We cannot process or pay your claim until you confirm your current, valid address and contact information.

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If the claimant listed above is deceased, the SFDCT cannot process or pay the claim unless the SFDCT receives: 1. An original death certificate for the claimant; 2. Estate Documentation identifying the person who has been appointed as executor or personal representative with authority to act on behalf of the estate of the claimant; and 3. The address and contact information of the authorized estate representative.

Settlement Facility - Dow Corning Trust

Enclosure: Address Update/Correction Form
CC: JAE-HEE KIM

ADDRESS UPDATE/CORRECTION FORM

1. Complete, correct and update claimant information.

PLACE YOUR LABEL HERE or WRITE IN YOUR INFORMATION USE THE PEEL-OFF LABEL PROVIDED IN YOUR PACKET	PROVIDE UPDATES OR CORRECTIONS BELOW:
1. SID #:	1. SID #: 2745881
2. Date of Birth:	2. Date of Birth:
3. Claimant's Name:	3. New Last Name:
4. Claimant's Address:	4. New Address: Suite 4105 Trade Tower, 511 Yeongdong-daero, Gangnam-gu, Seoul, Korea.
5. Daytime Phone: (____) ____-____	5. New Daytime Phone: (____) ____-____
6. Evening Phone: (____) ____-____	6. New Evening Phone: (____) ____-____
7. Attorney's Name/Address/Phone/Fax:	7. New Attorney's Name/Address/Phone/Fax:

Last 4 digits of Social Security Number (Required for residents of the United States):

For claimants without a social security number, please include a copy of the claimant's government-issued identification card that confirms the address.

☑ Please re-issue any outstanding payments in accordance with the payment procedures.

I declare under penalty of perjury that the information on this form is true, correct and complete to the best of my knowledge, information and belief.

2022 09 06
Date Signed

Yeonhokim
Signature
(Claimant or Court-Appointed Representative)

In order to be eligible for payment of settlement benefits, the claim must meet the definition of an eligible claim as set forth in Article V of Annex A. Additionally, please note that all deadlines for timely claimants to file a claim for benefits are linked to the Effective Date of the Plan – June 1, 2004. The SF-DCT cannot extend the deadlines listed to file a claim. For information on deadlines please visit our website at www.dcsettlement.com.

S F D C T
SETTLEMENT FACILITY
DOW CORNING TRUST

P.O. Box 52429
Houston, Texas 77052

Telephone 713.874.6099
866.874.6099

SUPPLEMENTAL FORM

Please provide the following information:

1. SID #: 27455881	5. Daytime Phone: (_____)_____-_____
2. Claimant's Name: _____	6. Evening Phone: (_____)_____-_____
3. Date of Birth: _____	7. Attorney's Name/Address/Phone/Fax:
4. Claimant's Address: _____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check the box below, sign and return this form with any additional records to cure the deficiencies in your claim on or before your Cure Deadline date.

☑ I am enclosing additional records or documents that I want the Facility to consider in the review of my claim.

☐ I accept the payment I am eligible to receive (an approved Disease Payment or the Expedited Release Payment).

Printed Name of Claimant

SID Number

yeonhokim

*Signature of Claimant, Executor/Administrator/Guardian or Attorney

2022. 11. 22

Date Signed

For assistance or questions call the Claims Assistance Program at 1.866.874.6099 (toll free)
Or go to www.dcsettlement.com on the Internet

< 2745881 >