

# **\$5,000 RUPTURE PAYMENT CLAIM FORM**

## **Instructions**

### **DOW CORNING OTHER PRODUCTS FUND (CLASS 9)**

Use this form to apply for the \$5,000 Rupture Payment if you have a ruptured Dow Corning silicone gel chin, facial or testicular implant. Please read these Instructions and the "Claimant Information Guide" carefully before completing the form.

#### **1. WHAT IS THE "OTHER PRODUCTS FUND"?**

The Other Products Fund ("the Fund") is a fund of \$36 million (Net Present Value) set aside solely to pay claims of persons who were implanted with an eligible Dow Corning implant (not a breast implant) after 1979. (Read Question 5 below and Section 5 in the Claimant Information Guide for more information about eligible implants.)

#### **2. WHAT IS THE \$5,000 RUPTURE PAYMENT?**

You will receive the \$5,000 Rupture Payment if your eligible Dow Corning silicone gel chin, facial or testicular implant is removed and is ruptured as defined in Question 4 below, and you submit the required proof by the deadline. (Read Section 6 in the Claimant Information Guide for more information about the Rupture Payment.)

#### **3. WHAT DO I HAVE TO DO TO RECEIVE THE \$5,000 RUPTURE PAYMENT?**

**First**, complete and submit the Proof of Manufacturer Form (the blue edge) and medical records or documents that show that you were implanted with a Dow Corning silicone gel chin, facial or testicular implant after 1979. (Read the Proof of Manufacturer Form Instructions.)

**Second**, complete and submit this form by the deadline and all of the following that show that your Dow Corning silicone gel chin, facial or testicular implant was ruptured:

1. A contemporaneous operative report from the implant removal surgery; and
2. If available, a contemporaneous pathology report documenting the rupture; and
3. If your Dow Corning implant was removed after the Effective Date, then you must also submit a statement from the surgeon who removed the implant (or other appropriate professional approved by the Settlement Facility) affirming that, in his or her opinion, the rupture did not occur during or after the implant removal surgery. This statement must describe the results of the inspection and provide a factual basis for the opinion. (Read Question Q1-4 in the Claimant Information Guide for more information about the Effective Date.)

The Claims Administrator may require that you present the removed implant for examination by an individual or entity designated by her to confirm the rupture and/or that the covered implant was manufactured by Dow Corning.

#### **DO NOT RETURN INSTRUCTIONS WITH FORM**

For assistance or questions call the Claims Assistance Program Toll Free at 1-866-874-6099 or go to [www.dcssettlement.com](http://www.dcssettlement.com) on the internet

#### 4. WHAT IS THE DEFINITION OF "RUPTURE"?

"Rupture" means the failure of the elastomer envelope surrounding a silicone gel chin, facial or testicular implant to contain the gel (resulting in contact of the gel with the body). There is no rupture if the gel's contact with the body is solely the result of gel bleed. The failure must be due to a tear or other opening in the envelope, and the tear or other opening must have occurred after implantation and before explantation.

#### 5. AM I ELIGIBLE FOR SETTLEMENT PAYMENTS IF MY DOW CORNING IMPLANT WAS IMPLANTED BEFORE 1980 (i.e., NOVEMBER 1979)?

You may complete and submit the Proof of Manufacturer Form (the blue edge) and this claim form to apply for a settlement benefit. The Claims Administrator has discretion to consider these claims if there are excess funds in the Other Products Fund.

#### 6. IF I RECEIVE THE RUPTURE PAYMENT, CAN I RECEIVE OTHER SETTLEMENT PAYMENTS FROM THE OTHER PRODUCTS FUND?

No.

#### 7. WHAT IS THE DEADLINE TO SUBMIT MY RUPTURE PAYMENT FORM AND MEDICAL RECORDS?

You must submit this claim form and the Proof of Manufacturer Form (the blue edge) with supporting medical records on or before two (2) years after the Effective Date. (Read Question Q1-4 in the Claimant Information Guide for more information about the Effective Date.

#### 8. WHAT IF I HAVE A PROBLEM OR RECEIVE A "DEFICIENCY NOTICE" ON MY RUPTURE CLAIM? IS THERE A DEADLINE TO SUBMIT ADDITIONAL DOCUMENTS TO CORRECT THE PROBLEM?

If there is a problem with either your Rupture Payment Claim Form (the green edge) or medical records, you will receive a letter from the Settlement Facility informing you of the problem. You will have six (6) months from the date of that letter to correct the problem. If you do not correct the problem within this six (6) month period, then your rupture claim will be rejected permanently. Because of this short time to correct problems, it is important that you review your medical records carefully before you send them in for review.

If your medical records meet the proof requirements described in Question 3 above, then you will receive a letter from the Settlement Facility informing you that your claim is approved. Approved claims will be paid as soon as reasonably practicable after the second anniversary after the Effective Date.

#### 9. WHO CAN I CONTACT IF I HAVE A QUESTION OR NEED HELP?

The Claims Assistance Program is available to answer questions about how to complete the forms in your Claims Package. They can also assist you with information on how to obtain the medical records and documents to support your claim. There is no charge to you for this service.

Call **Toll Free** at 1-866-874-6099 or go to [www.dcsettlement.com](http://www.dcsettlement.com) on the internet.

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

**AFFIX YOUR LABEL HERE**

#### **PROVIDE UPDATES OR CORRECTIONS BELOW:**

1. 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. I am making a claim for the \$5,000 Rupture Payment.**

- ☐ My Dow Corning silicone gel chin, facial or testicular implant was removed and was ruptured. My medical records for the ruptured Dow Corning silicone gel chin, facial or testicular implant are attached. (Please keep a copy for your file.)

### **3. Sign and return the Rupture Payment Form and your medical records on or before two (2) years after the Effective Date.** (If your ruptured Dow Corning silicone gel implant was removed within ninety (90) days immediately before the second (2nd) anniversary of the Effective Date, then your Rupture Payment Claim Form and medical records must be returned on or before thirty (30) days after the second (2nd) anniversary of 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.

Date Signed \_\_\_\_\_

Signature of Claimant, Executor/Administrator, or Guardian \_\_\_\_\_

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