

**\$700 (U.S.) EXPEDITED RELEASE PAYMENT OR
DISEASE PAYMENT CLAIM FORM, OPTION 1**

I n s t r u c t i o n s

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for either 1) the \$700 (U.S.) Expedited Release Payment or 2) a Disease Payment ranging from \$4,200 - \$105,000 (U.S.) (including a Premium Payment). Please read these Instructions, the "Option 1 Claimant Information Guide" and the "Option 1 Disease Claim Information Guide" for more information.

A. WHAT IS THE \$700 (U.S.) EXPEDITED RELEASE PAYMENT, OPTION 1?

1. WHAT IS THE \$700 (U.S.) EXPEDITED RELEASE PAYMENT, OPTION 1?

You will receive the \$700 (U.S.) Expedited Release Payment simply by showing that you were implanted with a Dow Corning breast implant. If you accept this payment, you will not be able to receive a Disease Payment.

2. WHAT DO I NEED TO DO TO RECEIVE THE \$700 (U.S.) EXPEDITED RELEASE PAYMENT?

First, complete and submit the Proof of Manufacturer Form (the blue edge), Option 1 and medical records or documents that show that you were implanted with a Dow Corning breast implant.

Second, check Box 2A on the Expedited Release Payment Claim Form (the red edge) and return it to the Settlement Facility by the deadline.

3. WHAT IS THE DEADLINE TO APPLY FOR THE \$700 (U.S.) EXPEDITED RELEASE PAYMENT?

You must submit the Expedited Release Payment Claim Form (the red edge) on or before three (3) years after the "Effective Date." (*Read Question Q9-5 in the Option 1 Claimant Information Guide for more information about the Effective Date.*)

B. WHAT IS THE DISEASE PAYMENT, OPTION 1?

4. WHAT IS THE DISEASE PAYMENT, OPTION 1?

The Disease Payment provides payment ranging from \$4,200 - \$105,000 (U.S.) (including a Premium Payment) if you submit the medical records and documents that show that you have one (1) of the diseases or conditions listed below and you have a related disability or meet the severity criteria for that disease or condition.

There are nine (9) eligible diseases and conditions in Disease Options 1 and 2. The eligible diseases and conditions are:

Atypical Connective Tissue Disease (ACTD)
Atypical Neurological Disease Syndrome (ANDS)
Primary Sjogren's Syndrome (PSS)
Mixed Connective Tissue Disease (MCTD)/ Overlap Syndrome
Systemic Sclerosis / Scleroderma (SS)
Systemic Lupus Erythematosus (SLE)
Polymyositis (PM)
Dermatomyositis (DM)
General Connective Tissue Symptoms (GCTS)

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 on the internet

5. WHAT IS THE DIFFERENCE BETWEEN DISEASE OPTION 1 AND DISEASE OPTION 2?

Disease Option 1 uses the same medical criteria and definitions that were established in the original global settlement. If you are familiar with the Revised Settlement Program (RSP) or Foreign Settlement Program (FSP), these same criteria were also in the Fixed Benefit Schedule. These diseases include both classic and atypical presentations of certain rheumatic diseases listed above. It also includes two (2) conditions – Atypical Neurological Disease Syndrome (ANDS) and Atypical Connective Tissue Disease (ACTD) – that were defined in the original global settlement. Disease Option 1 requires that you provide documentation of a disability or severity that is related to your compensable disease or condition.

The compensable diseases in **Disease Option 2** were not part of the original global settlement. They were included in the RSP as the “Long Term Benefit Schedule.” In general, the medical criteria to qualify for a Disease Option 2 claim are more restrictive and require more medical documentation and laboratory testing than those in Disease Option 1. Also, certain diseases that are compensable in Disease Option 1 are not compensable in Disease Option 2, such as Primary Sjogren’s Syndrome, MCTD/Overlap Syndrome, ANDS and ACTD. Disease Option 2 compensates you based on the severity level of your compensable disease or condition. The payments for Disease Option 2 are higher than payments for Disease Option 1.

6. WHAT ARE THE PAYMENT BENEFITS FOR APPROVED DISEASE CLAIMS?

Disease Option 1 payment amounts are determined by your approved severity or disability level.

DISEASE OPTION 1 PAYMENT SCHEDULE

Any approved disease in Disease Option 1 with a severity or disability level of A, B, C or D	You must have proof that you have or had a Dow Corning breast implant and did not have a Bristol, Baxter or 3M silicone gel breast implant**		
	Base Payment	+ Premium Payment	= Total Payment
Severity / Disability Level A	\$ 17,500 (U.S.)	+ \$3,500 (U.S.)	= \$ 21,000 (U.S.)
Severity / Disability Level B	\$ 7,000 (U.S.)	+ \$1,400 (U.S.)	= \$ 8,400 (U.S.)
Severity / Disability Level C or D	\$ 3,500 (U.S.)	+ \$ 700 (U.S.)	= \$ 4,200 (U.S.)

** If you have acceptable proof that you have or had a Bristol, Baxter or 3M silicone gel breast implant, the Total Payment amount will be reduced by 50%.

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Disease Option 2 payment amounts are determined by the severity level of your approved compensable disease or condition.

DISEASE OPTION 2 PAYMENT SCHEDULE

Locate your approved disease or condition in Disease Option 2 below and the severity level of that disease or condition	You must have proof that you have or had a Dow Corning breast implant and did not have a Bristol, Baxter or 3M silicone gel breast implant**		
	Base Payment	+ Premium Payment	= Total Payment
Scleroderma (SS) or Lupus (SLE); Severity Level A	\$87,500 (U.S.)	+ \$17,500 (U.S.)	= \$105,000 (U.S.)
Scleroderma (SS) or Lupus (SLE); Severity Level B	\$70,000 (U.S.)	+ \$14,000 (U.S.)	= \$ 84,000 (U.S.)
Scleroderma (SS) or Lupus (SLE); Severity Level C	\$52,500 (U.S.)	+ \$10,500 (U.S.)	= \$ 63,000 (U.S.)
Polymyositis (PM) or Dermatomyositis (DM) (there is only one severity level for PM and DM); General Connective Tissue Symptoms (GCTS), Severity Level A	\$38,500 (U.S.)	+ \$ 7,700 (U.S.)	= \$ 46,200 (U.S.)
General Connective Tissue Symptoms (GCTS); Severity Level B	\$26,250 (U.S.)	+ \$ 5,250 (U.S.)	= \$ 31,500 (U.S.)

** If you have acceptable proof that you have or had a Bristol, Baxter or 3M silicone gel breast implant, the Total Payment amount will be reduced by 50%.

7. CAN I COMPLETE THE DISEASE PAYMENT CLAIM FORM AND SEND MY MEDICAL RECORDS AND DOCUMENTS IN MY NATIVE LANGUAGE OR DO THEY HAVE TO BE IN ENGLISH?

You may submit the Disease Payment Form (the red edge) and medical records and documents in your own language. We will be able to process your claim faster though if you complete the claim form and have your medical records translated to English. (Read Question Q2-6 in the Option 1 Claimant Information Guide for more information.)

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8. I AM NOT SURE IF I HAVE LUPUS OR ACTD. THE DISEASE PAYMENT CLAIM FORM SAYS I MAY PICK ONLY ONE (1) DISEASE. HOW DO I DECIDE WHICH TO SELECT?

Consult with your doctor prior to completing the Disease Payment Claim Form about what disease or condition he or she has diagnosed or determined you may have. Check the box that matches your diagnosis and supporting medical records. If you check the box for either lupus, scleroderma, polymyositis, dermatomyositis or GCTS and do not qualify, then the Settlement Facility will review your claim for ACTD and/or ANDS if, in the judgment of the Settlement Facility, it appears that you may qualify for one (1) of these conditions.

9. WHAT IS THE DEADLINE TO SUBMIT A DISEASE CLAIM?

You must submit the Disease Payment Claim Form (the red edge) and supporting medical records on or before fifteen (15) years after the "Effective Date." (*Read Question Q9-5 in the Option 1 Claimant Information Guide for more information about the Effective Date.*) Before a disease claim can be reviewed or paid, you must also 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 breast implant.

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

If there is a problem with your disease claim, the Settlement Facility will inform you of the problem. You will have one (1) year from the date of the letter informing you of the deficiency to correct the problem. **If you do not correct the problem within this one (1) year period, then your disease claim will be denied, and you will be limited in the future to applying for a new compensable condition that manifests after the conclusion of the one (1) year period to cure the deficiency.**

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. Do not send your records to the Settlement Facility in a piecemeal fashion. Once a disease claim is received, the Settlement Facility will review and evaluate your claim based on the medical records and documents in your file at that time. If you have not submitted all of your medical records and documents that support your claim, then you will receive a deficiency notice letter informing you that your claim is being denied.

If your medical records meet the proof requirements described in the Option 1 Claimant Information Guide, then you will receive a letter from the Settlement Facility informing you that your claim is approved. Approved claims will be paid after the Effective Date.

11. 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.

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Use this form to apply for either the \$700 (U.S.) Expedited Release Payment **OR** a Disease Payment ranging from \$4,200 - \$105,000 (U.S.).

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

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 \$700 (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 \$700 (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.)

3. ☐ Check this box only if your disease claim was evaluated in the Revised Settlement Program (RSP) or the Foreign Settlement Program (FSP) 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 RSP or FSP, 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.

Date Signed

Signature of Claimant, Executor/Administrator, or Guardian