$750 (U.S.) EXPEDITED RELEASE PAYMENT OR LIMITED DISEASE PAYMENT CLAIM FORM, OPTION 4

Instructions

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for payment for either 1) a $750 (U.S.) Expedited Release Payment or 2) a Limited Disease Payment ranging from $3,600 (U.S.) to $18,000 (U.S.) (including a Premium Payment). Please read these Instructions and the Option 4 Claimant Information Guide carefully.

1. WHAT IS OPTION 4 -- THE $750 (U.S.) EXPEDITED RELEASE PAYMENT OR A LIMITED DISEASE PAYMENT?

Option 4 allows you to receive payment – at a reduced amount – if you do not meet the proof of manufacturer requirements in other Options (Options 1, 2 and 3). If your medical records of your breast implant surgery were destroyed because of a war or natural disaster that can be verified, you can apply for either a $750 Expedited Release Payment or a Limited Disease Payment. To receive payment, the name of your physician, hospital or clinic and the date of the implant surgery must match information from the sales records provided by Dow Corning.

2. WHAT ARE THE BRAND NAMES FOR DOW CORNING BREAST IMPLANTS?

Any of the following is an acceptable brand name for Dow Corning breast implants:

BRAND NAME	STATUS
Cronin	Acceptable if your breast implants were implanted in or from 1963 - 1971
Dow Corning	Acceptable
Dow Corning Wright	Acceptable
DC or DCW	Acceptable
Mueller, V. or V. Mueller	Acceptable if your breast implants were implanted after January 1, 1968 and before August 31, 1974
SILASTIC or Silastic	Acceptable
SILASTIC II or Silastic II	Acceptable
SILASTIC MSI or Silastic MSI	Acceptable
"silastic" - in all lower case letters	Acceptable if it is contained in a contemporaneous operative report for a breast implantation prior to 1969, provided that there is no other information in your records that is inconsistent with a Dow Corning product. This type of proof shall be used only if you do not have any explant records demonstrating a "Unique Identifier."
Varifil	Acceptable

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.dcsettlement.com on the internet

3. WHAT IS THE $750 (U.S.) EXPEDITED RELEASE PAYMENT, OPTION 4?

You will receive the $750 (U.S.) Expedited Release Payment simply by completing Questions 2-4 on the claim form and supplying enough information for the Settlement Facility to determine that you meet the requirements in Question 1 above.

4. IF I RECEIVE THE $750 (U.S.) EXPEDITED RELEASE PAYMENT, CAN I ALSO APPLY FOR OTHER SETTLEMENT PAYMENTS?

No.

5. WHAT IS THE LIMITED DISEASE PAYMENT, OPTION 4?

The Limited Disease Payment provides payment ranging from $3,600 - $18,000 (U.S.) (including a Premium Payment). You must submit 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. You must also meet the requirements in Question 1 above.

There are eight (8) eligible diseases and conditions. 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)

6. HOW MUCH IS THE LIMITED DISEASE PAYMENT?

The Limited Disease Payment is determined by the approved severity or disability level for your disease or condition. As long as you have at least one (1) of the diseases or conditions listed in Question 5 above, then use the chart below to find your severity or disability level to determine the payment.

Settlement Payment Option	Base Payment (U.S.)	Premium Payment (U.S.)
Limited Disease Payment		
Level One C or D	$ 3,000	$ 600
Level One B	$ 6,000	$ 1,200
Level One A	$ 15,000	$ 3,000

7. WHAT IS THE DEADLINE TO APPLY FOR THE $750 (U.S.) EXPEDITED RELEASE PAYMENT AND THE LIMITED DISEASE PAYMENT?

Complete and return your claim form and supporting records on or before fifteen (15) years after the Effective Date. *(Read Question Q9-5 in the Option 4 Claimant Information Guide for more information on the Effective Date.)*

8. IF I RECEIVE A LIMITED DISEASE PAYMENT, CAN I APPLY FOR OTHER SETTLEMENT BENEFITS?

No.

9. CAN I COMPLETE THIS CLAIM FORM AND SEND MY MEDICAL RECORDS AND DOCUMENTS IN MY NATIVE LANGUAGE OR DO THEY HAVE TO BE IN ENGLISH?

You may submit this claim form, 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 4 Claimant Information Guide for more information.)*

10. 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 on the internet.

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DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for either 1) a $750 Expedited Release Payment or 2) a Limited Disease Payment ranging from $3,600 to $18,000 (U.S.) (including a Premium Payment).

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 $750 (U.S.) Expedited Release Payment or Box 2B to apply for a Limited Disease Payment. Do not check both boxes.

2A. ☐ I am making a claim for the $750 (U.S.) Expedited Release Payment. Complete Questions 3A-F (these must be completed before your claim will be reviewed or paid) and sign the form at Question 7.

OR

2B. ☐ I am applying for a Limited Disease Payment. Proceed to Question 3.

♦ $750 (U.S.) EXPEDITED RELEASE PAYMENT OR LIMITED DISEASE PAYMENT CLAIM FORM, OPTION 4 ♦

3. To be eligible for Option 4 settlement payment, you must check boxes 3A and 3B and provide the information in 3C - 3F:

3A. ☐ All records about my breast implant surgery were destroyed by a war or natural disaster that can be verified; *and*

3B. ☐ The doctor who implanted me with Dow Corning breast implants has died or cannot be located.

3C. Describe the war or natural disaster that resulted in the destruction of your medical records for your breast implant surgery. Include enough detail on where your records were located and how they were destroyed so that the war or natural disaster can be verified and so that the Settlement Facility can determine that the war or natural disaster is connected to the loss of your records:

_____

_____

_____

_____

_____

_____

_____

3D. Complete the following chart regarding your breast implant history.

Date of Breast Implant Surgery	**Name of Physician, Hospital or Clinic For Breast Implant**	**City and Country of Implant**	**Manufacturer of Breast Implant** (if the manufacturer is unknown, write "Unknown")	**Date Breast 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

3E. Describe your efforts to locate the doctor, hospital or clinic where you were implanted with a Dow Corning breast implant and the results of your efforts:

_____

_____

_____

_____

_____

_____

3F. State the reasons why you believe that your implants were made by Dow Corning:

_____

_____

_____

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_____

_____

4. *Answer Question 4 only if you are applying for a Limited Disease Payment.*

4A. ☐ My disease claim was evaluated in the Foreign Settlement Program (FSP) or the Revised Settlement Program (RSP), and I want to rely on that existing evaluation. Go directly to Question 7 and sign and return the form. If you want to apply for a disease or disability/severity level that is different from your disease claim in the FSP or RSP, then proceed to Question 5.

5. *Choose only one (1) of the diseases or conditions below in 5A - 5H. 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).*

5A. ☐ I am making a claim for Atypical Connective Tissue Disease (ACTD), also called Atypical Rheumatic Syndrome (ARS) or Non-Specific Autoimmune Condition (NAC).

or

5B. ☐ I am making a claim for Atypical Neurological Disease Syndrome (ANDS).

or

5C. ☐ I am making a claim for Primary Sjogren's Syndrome (PSS).

or

♦ $750 (U.S.) EXPEDITED RELEASE PAYMENT OR LIMITED DISEASE PAYMENT CLAIM FORM, OPTION 4 ♦

5D. ☐ I am making a claim for Mixed Connective Tissue Disease/Overlap Syndrome (MCTD).

or

5E. ☐ I am making a claim for Systemic Sclerosis /Scleroderma (SS).

or

5F. ☐ I am making a claim for Systemic Lupus Erythematosus (SLE).

or

5G. ☐ I am making a claim for Polymyositis (PM).

or

5H. ☐ I am making a claim for Dermatomyositis (DM).

If you do not qualify for the disease or condition that you checked in Question 5C-5H, 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).

6. Please check either Box 6A or 6B below:

6A. ☐ Attached to this form are new or additional medical records that support my disease claim. *(Please keep a copy for your file.)*

6B. ☐ I have already submitted medical records and documents that support my disease claim, and I am not submitting any additional records.

7. Sign and return the form below 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