Appendix H

Claim Form

ACTOS RESOLUTION PROGRAM CLAIM FORM

INSTRUCTIONS

The Claim Package, including a completed copy of this Claim Form, must be submitted no later than the Claim Package Deadline for all Claimants, including unrepresented (*pro se*) Claimants, in the ACTOS Resolution Program (the "Program") outlined in the Master Settlement Agreement of April 28, 2015 (the "Agreement" or "MSA").

Counsel for Claimants may complete this Claim Form, but the Claimant must personally sign the Certification and Authorization in Section VII. All *Pro Se* Claimants must complete this Claim Form in its entirety.

I.A. ACTOS Product User

1. Actos Product User Name	Last	First	Middle
2. Social Security Number	_____ - _____ - _____	**Date of Birth**	____/____/____ (Month/Day/Year)
3. Address	Street/P.O. Box		
	City	State	Zip
4. Telephone Number	(_____) _____-_____	**5. Email**	
6. Any other names by which Actos Product User has been known, including but not limited to maiden name:	Last	First	Middle
	Last	First	Middle
	Last	First	Middle

I.B. PRIMARY COUNSEL INFORMATION

1. Attorney Name	Last	First	Middle	
2. Firm Name	Law Firm			
3. Address	Street			
	City	State	Zip	Country
4. Telephone Number	(_____) _____-_____	**5. Facsimile**	(_____) _____-_____	
6. Email				

I.C. CASE INFORMATION (if applicable)	
1. Court/Jurisdiction	
2. Case Caption	_____ v. _____
3. Case No.	

II. PERSONAL REPRESENTATIVE INFORMATION FOR MINOR, DECEASED, OR INCAPACITATED CLAIMANTS				
1. Is the Claim being brought regarding the Actos Product User by a Representative? **YES** ☐ **NO** ☐ If Yes, complete this Section II. If No, skip to Section III.				
2. Relationship to Product User (check all that apply)	☐ Spouse ☐ Administrator	☐ Parent ☐ Executor	☐ Child ☐ Other _____ (specify)	☐ Sibling
3. Representative's Name	Last	First	Middle	
4. Representative's Address	Street			
	City	State	Zip	Country
5. Representative's Telephone Number	(___) ___-____	**6. Email**		
7. SSN	___-___-___	**8. Date of Birth**	___/___/___ (Month/Day/Year)	
9. Death of Product User (if applicable)	___/___/___ (Month/Day/Year)	**10. Do you claim that ACTOS Products caused the Death?** (if applicable)	**YES** ☐	**NO** ☐

III. CLAIM INFORMATION	
ALLEGED INJURY LEVEL **Select the highest injury level category that can be proven by the records submitted as part of this Claims Package.**	
☐	**Level 1:** Diagnosis of Ta or Tis, low grade (G1 or G2), Bladder Cancer, as determined by a Pathology Report, OR diagnosis of Bladder Cancer without a recurrence with unspecified pathology classification. Product Users who had a diagnosis of Bladder Cancer prior to the use of ACTOS products, but who allege a recurrence of Bladder Cancer as a result of ACTOS usage are also included in this Injury Level 1.
☐	**Level 2:** Diagnosis of Ta or Tis, high grade (G), or T1 Bladder Cancer, OR the diagnosis of a recurrence of Bladder Cancer.
☐	**Level 3:** Diagnosis of T2 Bladder Cancer OR radiation therapy for the treatment of Bladder Cancer OR systemic (oral or intravenous) chemotherapy for the treatment of Bladder Cancer (not to include direct bladder treatments).
☐	**Level 4:** Diagnosis of T3 Bladder Cancer OR partial or radical cystectomy or nephrectomy for the treatment of Bladder Cancer. (A cystectomy is as a surgical procedure to remove all or part of the urinary bladder.)
☐	**Level 5:** Diagnosis of T4 Bladder Cancer OR death from Bladder Cancer. Death from Bladder Cancer must be proven by autopsy or death certificate attributing the death to Bladder Cancer as a primary or secondary cause of the death, or by a contemporaneous medical record reflecting that a qualified medical professional has determined Bladder Cancer to be a primary or secondary cause of the death.
CUMULATIVE ACTOS DOSAGE **Select the highest cumulative dosage category that can be proven by the records submitted as part of this Claims Package.**	
☐	Less than 900 mg, and Bladder Cancer was diagnosed three years or longer after last use of ACTOS Products as documented in contemporaneous Pharmacy or Medical Records.
☐	Less than 900 mg, and Bladder Cancer was diagnosed less than three years after last use of ACTOS Products as documented in contemporaneous Pharmacy or Medical Records.
☐	900 mg to 2,699 mg
☐	2,700 mg to 5,399 mg
☐	5,400 mg to 10,700 mg
☐	10,800 mg to 16,199 mg
☐	16,200 mg to 21,599 mg
☐	21,600 mg to 28,799 mg
☐	28,800 mg to 43,199 mg
☐	43,200 mg to 56,699 mg
☐	56,700 mg and above

EXTRAORDINARY INJURY CLAIM

Claimant must indicate below whether he or she is applying to be considered for an Extraordinary Injury Payment ("EI Payment"), as set forth in Section 7.02 of the Agreement. To be eligible to be considered for an EI Payment, Product User must (i) have Specified Documented Economic Damages of not less than $200,000; (ii) establish an injury of Bladder Cancer and have minor children at the time of the Product User's alleged injury; and/or (iii) establish extenuating circumstances relative to the Product User's alleged injury warranting compensation that are not otherwise addressed by the Points Award Process.

Please specify whether an EI claim is made by checking the applicable box below:

☐ Claimant **APPLIES** for an EI Payment based on Specified Documented Economic Damages of not less than $200,000;

☐ Claimant **APPLIES** for an EI Payment based on the Product User's injury of Death due to Bladder Cancer with minor children at the time of the Product User's alleged injury;

☐ Claimant **APPLIES** for an EI Payment based on extenuating circumstances relative to the Product User's alleged injury warranting compensation that are not otherwise addressed by the Points Award Process; OR

☐ Claimant **DOES NOT APPLY** for an EI Payment.

IV. CLAIM PACKAGE MATERIALS

Attach all Claim Package materials as required by Section 3.03 of the MSA. Indicate that you are submitting the following by checking the box(es) below:

☐	A completed and signed Claim Form.
☐	A completed and signed Authorization to Release Records and Other Information contained in Appendix I of the Agreement. The Claims Administrator can provide this form. When executing this document, the Claimant shall not specify particular healthcare providers for the collection of records, but shall leave the provider field of the form blank so that it may be utilized for collection of any necessary records in accordance with Section 8.05 of the MSA.
☐	Medical Records of Bladder Cancer diagnosis, as set forth in Section 3.03(A)(3)(i) of the MSA.
☐	Records reflecting proof of ACTOS Products usage, as set forth in Section 3.03(A)(3)(ii) of the MSA.
☐	Complete medical records from all healthcare providers who (i) diagnosed the Product User's Bladder Cancer; and/or (ii) provided treatment for the Product User's Bladder Cancer, as set forth in Section 3.03(A)(3)(iii) of the MSA.
☐	Medical records from all healthcare providers who prescribed ACTOS Products to the Product User, for the period spanning first alleged use of ACTOS Products through the last use of ACTOS products, as set forth in Section 3.03(A)(3)(iv) of the MSA.
☐	Medical records from all healthcare providers who served as the Product User's primary care provider, for the period spanning three years prior to the diagnosis of Bladder Cancer through the time of the diagnosis of Bladder Cancer, as set forth in Section 3.03(A)(3)(v) of the MSA.
☐	If Program Participant is alleging Bladder Cancer involving the urothelial lining of the renal pelvis, complete medical records from any nephrologist(s) who treated the Product User, as set forth in Section 3.03(A)(3)(vi) of the MSA.
☐	If death due to Bladder Cancer is alleged, a Death Certificate or Autopsy Report, as set forth in Section 3.03(A)(3)(vii) of the MSA.

☐	Wire instructions for use by the QSF Administrator, as set forth in Section 3.03(A)(4) of the MSA. The Claims Administrator will make this form available.
☐	Where the Claim is being brought in a representative capacity by a Program Participant who is not the Product User, documentation, such as letters of administration, sufficient to establish that the representative Program Participant is the duly authorized legal representative for the Product User or the Product User's estate, as set forth in Section 3.03(A)(5) of the MSA.
☐	A W-9 Form, which will be made available by the Claims Administrator, providing the information required by such form for Primary Counsel. Each Primary Counsel shall provide only one W-9 Form, as set forth in Section 3.03(A)(6) of the MSA.

V. CLAIMANT'S ELIGIBILITY FOR MEDICARE OR MEDICAID

A. Pursuant to the requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, codified at 42 U.S.C. 1395y(b)(7) and (b)(8), Claimant and Counsel for Claimant represent and warrant that the following information provided in this form is complete and accurate: (1) the Product User's Social Security Number; (2) the Product User's full legal name; and (3) the Product User's date of birth.

B. Certification Relating to Medicare and Medicaid Eligibility:

To the best of her knowledge, Claimant certifies, by indicating below, that

☐ Product User **IS** (or **WAS** prior to death) eligible to receive Medicare benefits.

☐ Product User **IS NOT** (or **WAS NOT** prior to death) eligible to receive Medicare benefits.

☐ Product User **IS** (or **WAS** prior to death) currently eligible to receive Medicaid benefits.

☐ Product User **IS NOT** (or **WAS NOT** prior to death) eligible to receive Medicaid benefits.

VI. CLAIMANT'S CERTIFICATION REGARDING BANKRUPTCY

Claimant certifies, by indicating below, that

☐ The Product User **HAS BEEN** (or **WAS** prior to death) a party in a bankruptcy action seeking bankruptcy protection.

☐ The Product User **HAS NOT BEEN** (or **WAS NOT** prior to death) a party in a bankruptcy action seeking bankruptcy protection.

VII. CERTIFICATION, AUTHORIZATION AND SIGNATURE

This form must be signed by Claimant (the ACTOS Product User or the legal representative of a deceased or incapacitated Product User).

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Claim Form is true and correct.

Product User/ Representative's Signature			**Date**	_____/_____/_____ (month) (day) (year)
Printed Name	First	MI	Last	