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

Instructions

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)

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%.

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.)*

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.

Call Toll Free at 1-866-874-6099 or go to www.dcsettlement.com on the internet.

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

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

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.*)

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

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

4 I. ☐ 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

$1,200 (U.S.) EXPEDITED RELEASE PAYMENT CLAIM FORM, OPTION 2

Instructions

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for the $1,200 (U.S.) Expedited Release Payment. Please read these Instructions and the Option 2 Claimant Information Guide for more information.

1. WHAT IS THE $1,200 (U.S.) EXPEDITED RELEASE PAYMENT, OPTION 2?

You will receive the $1,200 (U.S.) Expedited Release Payment simply by showing that you were implanted with a Dow Corning breast implant.

2. WHAT DO I NEED TO DO TO RECEIVE THE $1,200 (U.S.) EXPEDITED RELEASE PAYMENT?

Complete and submit this claim form. Also, send any of the following medical records or documents that show that you were implanted with a Dow Corning breast implant:

A. Hospital records of the surgeon's report of the breast implant surgery — written at or near the time of your implant surgery — that specify a Dow Corning brand name or Dow Corning as the manufacturer. The list of Dow Corning brand names is at Question 4 below.

B. A "certified copy" of your medical records that contains the breast implant package label demonstrating a Dow Corning breast implant. (*Read Question 3 below for a definition of "certified copy."*) Note: a certified copy is required *only if*:

1. The label is on a page that does not affirmatively reveal it to be a part of your hospital or medical records and does not have a lot number, serial number, or catalog number on it; ***or***
2. The hospital records are organized so that the breast implant label/sticker was put on a page by itself. If the page containing the breast implant label/sticker clearly comes from the hospital's contemporaneous record of the breast implant surgery, has other information relating to your hospitalization on that page, and has sufficient patient identification for the Settlement Facility to tell that it came from your records, it falls into the acceptable proof category of contemporaneous hospital records, and does not have to be certified.

C. Breast implant labels clearly marked with a *lot*, *serial* or *catalog* number. *(Read Question Q5-9 in the Option 2 Claimant Information Guide for information about lot, serial and catalog numbers of Dow Corning breast implants.)* These labels do not have to be certified.

D. Medical records of your implanting surgeon — written at the time of your breast implant surgery — that specify a Dow Corning brand name or Dow Corning as the manufacturer. The list of Dow Corning brand names is at Question 4 below.

E. An affirmative statement from your implanting physician (or a responsible person at the treating facility where your breast implant surgery took place) *attesting* that you were implanted with a Dow Corning breast implant. The person making this affirmative statement must also provide the *basis* for that conclusion. This type of proof is acceptable *only if:*

1. The records outlined in subparagraphs 2A and 2B above are not available; *and*
2. It must include a description of what steps were taken to try to secure the types of proof outlined in subparagraphs 2A and 2B above; *and*

3. It must explain why those records were not available. The statement of steps taken can be provided by your attorney if you are represented by counsel. This statement cannot rest upon "unacceptable proof" as defined in Question Q5-11 in the Option 2 Claimant Information Guide.

F. A health insurance claim form, signed by your implanting physician reasonably close to the date of the breast implant surgery, naming the type of breast implant used.

G. Medical records of the physician who removed your breast implant (or other physician or appropriate professional who examined your breast implant during or after removal surgery) — written at the time of the examination of your breast implant — if that physician or other appropriate professional points out a *specific characteristic* of the breast implant that is on the list "Unique Identifiers" for Dow Corning breast implants. The list of "Unique Identifiers" for Dow Corning breast implants is at Question Q5-8 in the Option 2 Claimant Information Guide.

H. A photograph of your removed breast implant that shows one (1) of the "Unique Identifiers" for a Dow Corning breast implant, as listed in Question Q5-8 in the Option 2 Claimant Information Guide, *if:*

1. The photograph is accompanied by a statement from the physician who removed your breast implant; *and*
2. (S)he identifies the breast implant in the photograph as one (s)he removed from you.

I. Dow Corning or brand-specific implant "control sheets", with cross-references to you, that reasonably appear to be contemporaneously kept records in the hospital or implanting physician's office. *(Read Question Q5-10 in the Option 2 Claimant Information Guide for a description of "control sheets.")*

J. Dow Corning's invoice or packing list contained in your medical or hospital records relating to the breast implant surgery. If the Settlement Facility cannot determine that the invoice or packing list actually was included in those records, they may require a "certified copy" of the records or a supplemental statement from the records custodian.

K. Dow Corning's catalog with a particular type or style of breast implant circled or otherwise marked, if contained in a "certified copy" of your medical or hospital records relating to the implant surgery, which were compiled and/or produced before or about the time of that surgery.

L. "Patient Informed Consent" forms signed by you and dated close to the date of your breast implant surgery, accompanied by other contemporaneous medical or hospital records verifying that the breast implant surgery actually occurred and identifying Dow Corning as the manufacturer of the breast implant.

M. Admissions in pleadings or letters written by Dow Corning to you, your representative or your physician acknowledging that your breast implants were manufactured by Dow Corning.

N. For breast implants implanted after July 1986, participation in Dow Corning's "Product Replacement Expense Program" ("PREP") as documented by a signed PREP brochure, statement, or similar document if contained in a "certified copy" of your contemporaneous medical or hospital records.

O. Participation in Dow Corning's "Removal Assistance Program" after March 1992 documented by correspondence enclosing payment for uninsured medical expenses issued under the program based on receipt of proper documentation. Dow Corning will

provide the names of persons it can document that participated in the Removal Assistance Program. If you are identified by Dow Corning as having participated in the Removal Assistance Program, the Settlement Facility will inform you of this, and you will not need to submit additional proof of manufacturer documents.

P. If you rely on the following standard, you must submit all of the following:

1. A Dow Corning invoice, sales receipt, packing statement, or import receipt that would ordinarily have accompanied a breast implant sold for implantation, where such invoice, receipt or statement references a Dow Corning breast implant; *and*
2. It must contain either the claimant's name or other information identifying the claimant; *and*
3. It must be accompanied by medical records that show that the claimant was later implanted with a Dow Corning breast implant within a reasonable amount of time after the date of the invoice, sales receipt, statement, or import receipt.

3. WHAT IS A "CERTIFIED COPY" OF A MEDICAL RECORD?

A certified copy is a copy of records with a certificate attached, usually signed by the custodian of records for that office or facility, affirming that the attached pages are true and accurate copies of records in a particular patient's file.

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

If the medical records or other documents are based on Question 2, paragraphs A-F or I-P above, then any of the following are an acceptable brand name for Dow Corning breast implants (*for information on paragraphs G and H in Question 2, read the Option 2 Claimant Information Guide at Section 5*):

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

5. 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 Q2-3 in the Option 2 Claimant Information Guide for more information.)*

6. IF I RECEIVE THE $1,200 (U.S.) EXPEDITED RELEASE PAYMENT, CAN I RECEIVE OTHER SETTLEMENT PAYMENTS?

No.

7. IS THERE A DEADLINE TO SUBMIT MY CLAIM FORM AND MEDICAL RECORDS OR DOCUMENTS?

Yes, you must submit your claim form and medical records or documents on or before three (3) years after the "Effective Date." (*Read Question Q6-5 in the Option 2 Claimant Information Guide for more information on the Effective Date.*)

8. 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.

$1,200 (U.S.) EXPEDITED RELEASE PAYMENT CLAIM FORM, OPTION 2

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for the $1,200 (U.S.) Expedited Release 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. ☐ I am applying for the $1,200 (U.S.) Expedited Release Payment.

I understand and agree that I cannot receive any other payment. I release all present and future claims related to my Dow Corning breast implant(s).

3. Check Box 3A or 3B.

3A. ☐ 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

3B. ☐ 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.)

♦ $1,200 (U.S.) EXPEDITED RELEASE PAYMENT CLAIM FORM, OPTION 2 ♦

4. *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

5. *Sign and return this form on or before three (3) years after the Effective Date.*

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.

______________________ Date Signed

______________________________________ Signature of Claimant, Executor/Administrator, or Guardian

$600 (U.S.) PROOF OF MANUFACTURER FORM, OPTION 3

Instructions

DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for the $600 (U.S.) Proof of Manufacturer Payment. Please read these Instructions and the Option 3 Claimant Information Guide for more information.

1. WHAT IS THE $600 (U.S.) PROOF OF MANUFACTURER PAYMENT, OPTION 3?

If you filed a "Proof of Claim" form with the United States bankruptcy court in Michigan on or before February 14, 1997, you will receive $600 (U.S.) if you complete and return this claim form on or before fifteen (15) years after the Effective Date. *(Read Question Q5-5 in the Option 3 Claimant Information Guide for more information on the Effective Date.)*

2. DO I HAVE TO SUBMIT ANY ADDITIONAL DOCUMENTS WITH THIS CLAIM FORM TO RECEIVE THE $600 (U.S.) PROOF OF MANUFACTURER PAYMENT?

No.

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

If you were implanted with any of the following brands, then you are eligible for the $600 (U.S.) Proof of Manufacturer Payment:

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

4. CAN I COMPLETE THIS CLAIM FORM IN MY NATIVE LANGUAGE OR DOES IT HAVE TO BE IN ENGLISH?

You may submit this claim form in your own language. We will be able to process your claim faster though if you complete it in English.

5. IF I RECEIVE THE $600 (U.S.) PROOF OF MANUFACTURER PAYMENT, CAN I RECEIVE OTHER SETTLEMENT PAYMENTS?

No.

6. 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.

$600 (U.S.) PROOF OF MANUFACTURER FORM, OPTION 3

FOR DOW CORNING BREAST IMPLANT CLAIMANTS (CLASS 6.2)

Use this form to apply for the $600 (U.S.) Proof of Manufacturer 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. ☐ I am applying for the $600 (U.S.) Proof of Manufacturer Payment.

I state under oath that I was implanted with a Dow Corning breast implant. I understand and agree that if I accept the $600 (U.S.) Proof of Manufacturer Payment, I cannot receive any other payment.

3. Sign and return this form on or before fifteen (15) years after the Effective Date.

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. I release all claims against Dow Corning, the Released Parties and the Settlement Facility that I have now or may have in the future arising from my Dow Corning breast implant(s) or any component materials in my implants.

_____ _____
Date Signed Signature of Claimant, Executor/Administrator, or Guardian

● $600 (U.S.) PROOF OF MANUFACTURER FORM, OPTION 3 ●

$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

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

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.

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

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:

_____

_____

_____

_____

_____

_____

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