

REQUEST FOR REVIEW OF ADDITIONAL EXPLANT INFORMATION

You must complete this form and return if you have additional information that you want the Settlement Facility – Dow Corning Trust to consider for your Explant claim.

1. Complete and update claimant information.	
PLACE YOUR LABEL HERE or WRITE IN YOUR INFORMATION <u>USE THE PEEL-OFF LABEL PROVIDED IN YOUR PACKET</u>	<u>PROVIDE UPDATES OR CORRECTIONS BELOW:</u>
1. SID #: _____	1. SID #: _____
2. Date of Birth: _____	2. Date of Birth: _____
3. Claimant's Name: _____	3. New Last Name: _____
4. Claimant's Address: _____ _____	4. New Address: _____ _____
5. Daytime Phone: (____) ____ - _____	5. New Daytime Phone: (____) ____ - _____
6. Evening Phone: (____) ____ - _____	6. New Evening Phone: (____) ____ - _____
7. Attorney's Name/Address/Phone/Fax: _____ _____	7. New Attorney's Name/Address/Phone/Fax: _____ _____

2. I have additional medical information that I want the Facility to consider and I have attached it to this form. (Please keep a copy of all records for your file and write your name and ID on all medical records in red ink). The additional information concerns my Explant Payment claim.

Please remember you have six (6) months from the date of your first Notification of Status letter to cure your deficiency or your Explant Claim will be permanently denied.

*Signature of Claimant, Executor/Administrator/Guardian or Attorney (Please circle one) Date Signed

***Forms with invalid signatures will be returned unprocessed.**