REQUEST FOR REVIEW OF ADDITIONAL RUPTURE 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 Rupture claim.

1. Complete and update claimant information.

PLACE YOUR LABEL HERE **or** **WRITE IN YOUR INFORMATION** USE THE PEEL-OFF LABEL PROVIDED IN YOUR PACKET	**PROVIDE UPDATES OR CORRECTIONS BELOW:**
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 Rupture Payment claim.

☐ **3.** I want to participate in the Individual Review Program (IRP). I have medical documentation that meets the following criteria:

> Medical documentation, created before explantation surgery or within a reasonable time after explantation of the Dow Corning single or double-lumen silicone gel Breast Implant, demonstrating visual confirmation of a breach in the elastomer envelope found upon or prior to removal of the Dow Corning silicone gel Breast Implant,
> or
> Medical documentation demonstrating migration along tissue planes distant from the site of breast implantation of a substantial mass of material confirmed by biopsy to be silicone from a ruptured Dow Corning single or double-lumen silicone gel Breast Implant.

Please remember you have six (6) months from the date of your first Notification of Status letter to cure your deficiency or your Rupture 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.**

For assistance or questions call the Claims Assistance Program at 1.866.874.6099 (toll free)
Or go to www.dcsettlement.com on the Internet