Combustion Engineering 524(g) Asbestos PI Trust
– Claim Form –

General Instructions for filing this Claim Form:

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; ***submitting an incomplete form may result in delays in processing and/or the Trust not being able to assign the claim a position in the first-in-first-out (FIFO) processing queue***. Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the review election which best suits the injured party's situation:

☐ Expedited ☐ Individual ☐ Extraordinary ☐ Secondary Exposure

If requesting exigent treatment, check here: ☐ Exigent Hardship

Law Firm's matter number for this claim: _____

Section 1: Injured Party Information				
Last Name	First Name		Middle Name	Suffix
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Date of Death (mm/dd/yyyy) (if applicable)	Was death asbestos related? ☐ Yes ☐ No
Mailing Address (if not represented by counsel)				
City	State	Zip	Daytime Telephone	

Section 2: Law Firm / Attorney Information			
If represented by counsel, please provide the following information.			
Law Firm Name			Filer ID
Mailing Address			
City		State	Zip Code
Attorney Last Name	Attorney First Name	Attorney Middle Name	Attorney Suffix
Direct Telephone	Facsimile	E-mail Address	

Section 3: Asbestos Related Injury

Check the box next to the highest disease level the injured party is claiming.

Disease Level

☐ Other Asbestos Disease (Level I)
☐ Asbestosis / Pleural Disease (Level II)
☐ Asbestosis / Pleural Disease (Level III)
☐ Severe Asbestosis (Level IV)
☐ Other Cancer (Level V)
☐ Lung Cancer 2 (Level VI)
☐ Lung Cancer 1 (Level VII)
☐ Mesothelioma (Level VIII)

Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level V), please specify malignancy

Section 4: Smoking History *(required only for Individual Review Claims for Lung Cancer 1 (Level VII) and Lung Cancer 2 (Level VI))*

In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of said products smoked per day.

Product	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
☐ Cigarettes ☐ Cigars ☐ Pipes			
☐ Cigarettes ☐ Cigars ☐ Pipes			
☐ Cigarettes ☐ Cigars ☐ Pipes			

Section 5: Personal Representative *(if applicable)*

Last Name	First Name	Middle Name	Suffix

Social Security Number (optional)	Capacity of Personal Representative ***(i.e. Administrator, Executor, Guardian, etc.)***

Mailing Address			
City	State	Zip	Daytime Telephone

Section 6: Asbestos Litigation and Claims History

If an asbestos-related lawsuit or claim has ever been filed on behalf of the injured party, please provide the following information.

Filing Date (mm/dd/yyyy)	State	Court	Docket Number

CE named as defendant? ☐ Yes ☐ No	Has the injured party ever received money for an asbestos-related injury or asbestos claim from CE, CE's insurers, or the CE Settlement Trust? ☐ Yes ☐ No	If "yes", amount: $_____

Jurisdiction Selection

If no lawsuit has ever been filed against CE on behalf of the injured party, indicate the state elected as the Claimant's Jurisdiction: _____

Jurisdiction elected is (please check one of the following):

☐ The state in which the injured party resided at the time of diagnosis.
☐ The state in which the injured party resides when this claim is filed with the Trust.
☐ A state in which the injured party experienced exposure to an asbestos-containing product, or to conduct that exposed the injured party to an asbestos-containing product, for which CE has legal responsibility.

Section 7: Occupational Exposure to Asbestos Products

Provide information below for each location at which the injured party alleges exposure to an asbestos-containing product, or to conduct that exposed the claimant to an asbestos-containing product, for which CE has legal responsibility. If the duration of the injured party's CE Exposure is not sufficient to meet the other exposure criteria (Significant Occupational Exposure or cumulative occupational exposure) for the Disease Level in question, please provide information regarding other asbestos exposure to satisfy the applicable exposure criteria. List each site, industry, and occupation combination separately. Provide the complete name and location of each individual site. Attach additional copies of this page if more space is required.

Part 1

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation

Site of Exposure (name of plant, site, ship or vessel)	City	State	Country

Industry in which exposure occurred (see Industry Codes attached as Exhibit A to the Instructions for Filing Claims.) If Industry Code OT (other) is designated, specify the other industry:

Names of all asbestos-containing products to which injured party was exposed and for which injured party alleges CE is legally responsible.

Description of Significant Occupational Exposure at this jobsite (check all that apply)

☐ Injured party handled raw asbestos fibers on a regular basis.

☐ Injured party fabricated asbestos-containing products such that the injured party in the fabrication process was exposed on a regular basis to raw asbestos fibers.

☐ Injured party altered, repaired, or otherwise worked with an asbestos-containing product such that the injured party was exposed on a regular basis to raw asbestos fibers.

☐ Injured party was employed in an industry and occupation such that the injured party worked on a regular basis in close proximity to workers engaged in one or more of the above three activities.

☐ Other (please describe in as much detail as possible):

Part 2

If the injured party is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claim satisfies Section 5.4(a) of the TDP:

Section 8: Secondary Exposure

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person (OEP), the claimant must provide the information below. Please also complete Section 7, Part 1 with the exposure information for the OEP. Claims resulting solely from exposure to an OEP may be submitted to the Trust pursuant to Individual Review.

Date Exposure to OEP Began (mm/dd/yyyy)	Date Exposure to OEP Ended (mm/dd/yyyy)	Relationship to OEP

Description of how injured party was exposed through the OEP to an asbestos-containing product, or to conduct that exposed the injured party to an asbestos-containing product, for which CE has legal responsibility:

Section 9: Employment / Earnings Information *(required only for claims for lost wages or Exigent Hardship Claims based upon lost wages)*

If economic losses are being claimed, please enclose an economic loss report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)		
☐ Full-time	☐ Part-time	☐ Retired
☐ Partially Disabled	☐ Fully Disabled	☐ N/A (deceased)
Amount of last annual wages	Date of last wages received (mm/dd/yyyy)	

Section 10: Dependents *(not required for Expedited Review)*

List injured party's spouse and/or any other dependents.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Section 11: Certification and Signature

This claim form must be signed by the injured party's attorney or, if the injured party is not represented by an attorney, the injured party or the injured party's personal representative.

If signed by an attorney, by signing below, the attorney certifies that the attorney is authorized to file this claim and that the information and materials with respect to this claim, submitted now or in the future, including any supplemental documentation or information, changes and corrections, are and will be submitted pursuant to and subject to the provisions of Rule 11 of the Federal Rules of Civil Procedure as if the submissions were a paper presented to a court of the United States. In addition, by signing below, the attorney certifies and warrants that if this claim is filed on behalf of the injured party and/or the injured party's estate, the person filing the claim is authorized by law to file this claim on behalf of the injured party, the injured party's heirs, representatives, successors, assigns and estate.

If signed by the injured party or personal representative, I (the injured party or personal representative) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. I hereby certify, under penalty of perjury, the information submitted is accurate.

Signature of Injured Party, Personal Representative, or Attorney	Date Signed (mm/dd/yyyy)

Print Name Here

Signatory's Relationship to Injured Party

To file by mail, send this completed form and all supporting documentation to:

Combustion Engineering 524(g) Asbestos PI Trust
c/o Verus Claims Services, LLC
3967, Princeton Pike
Princeton, NJ 08540

Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form.

For all claimants:

☐ Medical records supporting the diagnosis of the claimed Disease Level (see filing instructions for requirements).

☐ Proof of CE Exposure, as set forth in the filing instructions.

For deceased injured parties:

☐ Death certificate.

For claims for lost wages or Exigent Hardship Claims based upon lost wages:

☐ Documentation supporting the claim that any and all wage loss incurred by the injured party was the result of the injured party's asbestos-related disease. This documentation would include, but not be limited to, medical records and/or reports, reports from governmental or insurance agencies and/or reports from the injured party's most recent employer.

☐ Tax returns and/or W-2 forms for the last three (3) full years of employment.

Other supporting documentation, as applicable:

☐ Letters of Administration or other proof of the personal representative's official capacity (if applicable).

If you are filing an Individual Review claim and have additional information (see TDP section 5.3(b)(2)) you would like the Trust to consider in evaluating your claim, please include any related documents or information with the Claim Form.