

**AWI ASBESTOS PERSONAL INJURY SETTLEMENT TRUST
PROOF OF CLAIM FORM**

Part 1: Injured Party Information

1. Name: _____ (Last) (First) (MI)		
2. Social Security Number: _____ - _____ - _____		
3. Gender: Male _____ Female _____	4. Date of Birth: _____ / _____ / _____ (month) (day) (year)	

5. Is injured party living? Yes _____ No _____

6. If injured party is deceased, please complete the following: **(Death Certificate must be enclosed)**

6a. Date of death: _____ / _____ / _____
(month) (day) (year)

6b. Was death asbestos-related? Yes _____ No _____

7. If injured party is living and not represented by counsel, please complete the following:

7a. Mailing address: _____
(street/PO Box)

(city/state/zip)

7b. Daytime Phone: () _____ - _____

7c. Email Address: _____

8. If injured party is deceased or has a personal representative or heir other than, or in addition to, his/her attorney, please indicate the following for the representative. **(Certificate of Official Capacity or other estate documentation must be enclosed if applicable per state law.)**

8a. Name: _____
(Last) (First) (MI)

8b. Social Security Number: _____ - _____ - _____ , or Tax ID Number: _____

8c. Mailing Address: _____
(street/PO Box)

(city/state/zip)

8d. Daytime Phone: () _____ - _____

8e. Email Address: _____

8f. Relationship to injured party: _____
(spouse, child, etc.)

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Part 2: Diagnosed Asbestos-related Injuries

1. Place an X next to the highest level (most serious) asbestos-related Disease Category that has been diagnosed for the injured party and for which medical documentation is attached to this claim form. See instructions for a list of specific medical criteria and records that must be enclosed for each Disease Category. **(Check only the most serious)**

<u>Level</u>	<u>Scheduled Disease</u>
<input type="checkbox"/>	VIII Mesothelioma
<input type="checkbox"/>	VII Lung Cancer I
<input type="checkbox"/>	VI Lung Cancer 2 (Individual Review Only)
<input type="checkbox"/>	V Other Cancer (Please specify: _____)
<input type="checkbox"/>	IV Severe Asbestosis (ILO of 2/1 or greater, or asbestosis determined by pathology plus (a) TLC less than 65 % or (b) FVC less than 65% plus FEV1/FVC ratio greater than 65%)
<input type="checkbox"/>	III Asbestosis/Pleural Disease (Bilateral Asbestos-Related Non-Malignant Disease plus (a) TLC less than 80% or (b) FVC less than 80% and FEV1/FVC ratio greater than or equal to 65%)
<input type="checkbox"/>	II Asbestosis/Pleural Disease (Bilateral Asbestos-Related Non-Malignant Disease)
<input type="checkbox"/>	I Other Asbestos Disease (Cash Payment Discount, not subject to the Payment Percentage)

2. Date of Diagnosis: _____/_____/_____
(month) (day) (year)

The claims must meet the relevant medical criteria and be supported by appropriate medical documentation as defined in the Asbestos Personal Injury Trust Distribution Procedures. The presumptive medical criteria for the Disease Categories set forth above are included in the instructions.

- For claims filed against AWI or any other asbestos defendant in the tort system prior to the Petition Date (December 6, 2000), please check this box if you have a report of a diagnosing physician who conducted the physical exam of the claimant, or you have filed such a report with B&W or another defendant in the tort system or another asbestos-related personal injury settlement trust. (see sections 5.7(a)(1)(a) and 5.7(a)(1)(c) of the TDP)

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Part 3: Exposure to Asbestos Operations, Activities or Products

Proof of Significant Occupational Exposure (“SOE”) to asbestos-related products as well as proof of AWI Exposure (*i.e., qualifying exposure to AWI Products/Operations, as defined below and as set out in the instructions*) must be enclosed as required by Asbestos Personal Injury Trust Distribution Procedures sections 5.3 and 5.7(b). (See instructions) ***Please photocopy this section and list separately each company site, industry, and occupation combination upon which you rely to meet the exposure requirements of the TDP.***

“AWI Products/Operations” means asbestos or asbestos-containing products manufactured, produced, distributed, sold, fabricated, installed, released, maintained, repaired, replaced, removed, and/or handled by AWI or any entity, including an AWI contracting entity, for which AWI is responsible.

Please include detail concerning all asbestos exposure (not just AWI Exposure) which you think is sufficient to meet the criteria for approval of the claim at the claimed disease level. List each site, industry and occupation combination separately.

For AWI Exposure, a list of approved AWI sites is available on the Trust website (www.armstrongworldasbestostrust.com). Please reference this list and enter the Approved AWI Site Code in item #1 below.

If the site where you are alleging exposure to AWI Products/Operations is not on the approved AWI site list or your occupation is not on the Presumptive Company Exposure List of occupations, provide independent documentation of meaningful and credible evidence of exposure to such AWI Products/Operations. This may be established by documentation including, but not limited to, the following:

- *An affidavit of the injured party (an example is included on the Trust website)*
- *An affidavit of a co-worker*
- *An affidavit of a family member in the case of a deceased claimant*
- *Invoices*
- *Construction or similar records*
- *Sworn statement, interrogatory answers, sworn work history, or deposition*
- *Description of exposure to AWI Products/Operations, if required*

1. Site/Plant where exposure occurred:
Name of Site/Plant of Asbestos Exposure: _____, or
if this site is on the approved AWI site list, enter the Site Code from Exhibit A (available on
website): _____ (if a Site Code is entered, please skip to question 2)

City: _____

State/Province: _____

Country: _____

If this exposure involved products manufactured, produced, distributed, sold, fabricated, installed, released, maintained, repaired, replaced, removed, and/or handled by AWI or any entity, including an AWI contracting entity, for which AWI is responsible, identify the products and provide the evidentiary basis for the claim that these products were at that site.

2. Date Exposure Began: ____/____/____ Date Exposure Ended: ____/____/____
(month) (year) (month) (year)

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3. Occupation at Time of Exposure (*e.g.*, Boilermaker, Laborer, etc.): _____

4. Industry in which exposure occurred: _____ (Industry codes listed below)

If Code 37 - Other, please describe: _____

Industry Codes

- | | |
|---|------------------------------------|
| 10. Asbestos mining | 24. Petrochemical |
| 11. Aerospace/aviation | 25. Insulation |
| 12. Asbestos abatement | 27. Railroad |
| 13. Automobile/mechanical friction | 30. Shipyard-construction/repair |
| 16. Chemical | 31. Textile |
| 17. Construction trades | 32. Tire/rubber |
| 18. Iron/steel | 33. Utilities |
| 19. Longshore | 34. Asbestos products manufacturer |
| 20. Maritime | 36. Building occupant |
| 21. Military | 37. Other |
| 23. Non-asbestos products manufacturing | |

5. Is occupation/industry on the Presumptive Company Exposure List? Yes ___ No ___

6. **Significant Occupational Exposure** If your occupation does not appear on the list of Presumptive SOE Occupations Ratings (available at www.armstrongworldasbestostrust.com), please advance directly to question 7. If it does appear on the list, indicate circumstances of exposure to asbestos products or activities (check all applicable):

- 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 asbestos fibers
- Injured party was employed in an industry or occupation such that the injured party worked on a regular basis in close proximity to workers who did one or more of the above three activities
- None of the above

7. **Significant Occupational Exposure** If the injured party's occupation *does not* appear on the list of Presumptive SOE Occupations Ratings, or "None of the above" was checked in question 6 above, provide a description of how the injured party was exposed to asbestos.

8. If this exposure is in support of *Exposure to an Occupationally Exposed Person* from Part 4, please enter the name of the occupationally exposed individual:

_____ (Last) _____ (First) _____ (MI)

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Part 4: Exposure from an Occupationally Exposed Person

Note: If a claimant alleges an asbestos-related disease resulting solely or in part from exposure to an occupationally exposed person, such as a family member, the claimant must seek Individual Review of his or her claim pursuant to Sections 5.3(b) and 5.5 of the Trust Distribution Procedures. See Choice of Claim Process box on first page of this claim form.

1. Is the claimant alleging an asbestos-related disease resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)?

Yes _____ No _____

If yes, Part 3 must also be completed for each occupationally exposed person.

2. Date exposure to other person began: _____/_____
(month) (year)

3. Date exposure to other person ended: _____/_____
(month) (year)

4. Relationship to occupationally exposed individual:

(brother, son, spouse, etc.)

5. Social Security Number of occupationally exposed individual: _____ - _____ - _____

6. Describe how injured party was exposed through the occupationally exposed individual to the AWI products or conduct:

Reminder: Part 3 must be completed for the occupationally exposed person. If the injured party also had direct, occupational exposure to asbestos, Part 3 must also be completed for that exposure.

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Part 7: Smoking History

For each item, indicate whether the injured party has smoked. Please indicate the dates cigarettes or cigars were used, and the amount per day. Indicate fractional packs or fractional cigars as appropriate, *e.g.*, three and one-half packs would be entered as 3.5. ***This is to be completed for Lung Cancer 2 (LC2) and IR levels I through IV only.***

1. Has the injured party ever Smoked Cigarettes?		Yes _____ No _____
1a. From: _____/_____ (month) (year)	To: _____/_____ (month) (year)	
1b. Packs per day: _____ (use decimal)		

1. Has the injured party ever Smoked Cigars?		Yes _____ No _____
1a. From: _____/_____ (month) (year)	To: _____/_____ (month) (year)	
1b. Cigars per day: _____ (use decimal)		

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Part 8: Employment Information for Economic Loss

This is to be completed for IR claims only.

1. Current Employment Status of the injured party:

- Full-time, outside the home
- Full-time, within the home
- Part-time, outside the home
- Part-time, within the home
- Retired
- Disabled
- Deceased

2. Amount of last annual wages: \$ _____

3. Date of last wage received: ____/____/____
(month) (year)

(Enter current date if currently earning work-related compensation.)

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

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Part 9: Signature Page

All claims must be signed by the claimant, or the person filing on his/her behalf (such as the personal representative or attorney).

If signed by the claimant or the personal representative, I (the claimant or personal representative) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge, under penalty of perjury, the information submitted is accurate and complete.

If signed by the claimant's counsel, I (counsel to the claimant or personal representative) certify that the information and materials with respect to this claim are being submitted pursuant to and subject to the provisions of Rule 11 of the Federal Rules of Civil Procedure.

Signature of claimant, personal representative, or claimant's counsel.

Please print the name and relationship to the claimant of the signatory above.

Date: ____/____/____
(month) (day) (year)

Please review your submission to ensure it is complete and includes the following documents as applicable.

- Death Certificate (if applicable)
- Certificate of Official Capacity or other estate documentation (if personal representative is filing form) if applicable per state law.
- Medical Records as required by the Trust Distribution Procedures and as requested in the instructions
- Proof of AWI exposure and Significant Occupational Exposure as required in the Trust Distribution Procedures and requested in the instructions, including affidavits from the injured party or others.
- Copy of the tolling agreement (if applicable in Part 5)
- Documentation of Economic Loss (if Part 8 is applicable)

If you are filing an IR claim and have additional information (see TDP section 5.3(b)(2)) you want the Trust to consider in evaluating your claim, please include these documents with the Claim Form.