

CLAIM FORM

IRC

INDIVIDUALIZED REVIEW CLAIM

EAGLE PICHER INDUSTRIES PERSONAL INJURY SETTLEMENT TRUST

Submit completed claims to:

Claims Processing Facility, Inc.
East-West Tech Center
1771 W. Diehl Road
Suite 220
Naperville, IL 60563

Instructions for the Individualized Review Claim Form

Complete this claim form as thoroughly and accurately as possible. Please type or print neatly.

Should there be insufficient space to list all relevant information, please attach additional sheets.

In addition to filing the forms that follow, please ensure the following are enclosed, if applicable:

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as requested in instructions
- Proof of Eagle-Picher product exposure as set out in instructions
- W-2 and first page of 1040 for last year of full employment

Representation

If Claimant is represented by counsel, please print or type the following information:

Attorney Name: _____
(Please print full name)

Paralegal or Contact Name: _____
(Please print full name)

Name of Law Firm: _____
(Please print full name of firm)

Firm Address: _____
(Street/PO box number/suite number)

(City, State and Zip)

Attorney Phone: _____ **Fax:** _____
(Area Code & Number) (Area Code & Number)

Contact Phone: _____ **Fax:** _____
(Area Code & Number) (Area Code & Number)

Part 1: Injured Party Information

Name: _____ <small>(Please print FULL NAME)</small>	Social Security #: _____ - _____ - _____
Gender: Male: _____ Female: _____	Date of Birth: _____ / _____ / _____ <small>(Month) (Day) (Year)</small>

I. Is injured party living? Yes: _____ No: _____

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

Mailing Address: _____
(Street/PO box)

_____ (City/State/Zip)

Daytime Phone: () _____ - _____

III. If injured party is deceased: (***Death Certificate must be enclosed***)

Date of Death: _____ / _____ / _____

Was death asbestos related? Yes: _____ No: _____

IV. If injured party has a personal representative other than, or in addition to, his/her attorney, please indicate the following information for the representative: (**Certificate of Official Capacity must be enclosed.**)

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____

Daytime Phone: () _____ - _____

Relationship to Injured Party: I am party's: _____

(Guardian, Administrator, Brother, etc.)

Part 2: Dependents and Beneficiaries

List any other persons who may have rights associated with this claim.

Be sure to include the injured party's spouse, any dependents who derive (or who did derive at the time of the injured person's death) at least one-half of their financial support from the injured party.

Also list beneficiaries who are entitled to pursue an action for wrongful death under applicable state law.

If more than three, please photocopy this page, and insert after current page.

Name of Dependent/Beneficiary _____		Date of Birth: ____/____/____ <small>(Month) (Day) (Year)</small>	
Relationship:	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Dependent/Beneficiary _____		Date of Birth: ____/____/____ <small>(Month) (Day) (Year)</small>	
Relationship:	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Dependent/Beneficiary _____		Date of Birth: ____/____/____ <small>(Month) (Day) (Year)</small>	
Relationship:	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide any additional information on any financial dependents or beneficiaries you believe to be relevant, such as whether they are handicapped or have extraordinary needs: _____

Part 3: Diagnosed Asbestos-Related Injuries

Place an X next to all injuries below that have been or were diagnosed for the injured party **and** for which medical documentation is attached to this claim form. *See Instruction Letter for listing of medical records that must be enclosed.*

<input type="checkbox"/>	Mesothelioma	Date of Diagnosis _____/_____/_____
		(Month) (Day) (Year)
<input type="checkbox"/>	Lung Cancer	Date of Diagnosis _____/_____/_____
		(Month) (Day) (Year)
<input type="checkbox"/>	Other Cancer: _____	Date of Diagnosis _____/_____/_____
	<i>Indicate type</i>	(Month) (Day) (Year)
<input type="checkbox"/>	Non-malignancy (e.g., asbestosis, pleural lung disease)	Date of Diagnosis _____/_____/_____
		(Month) (Day) (Year)

Total expenditure on diagnosis and treatment of asbestos-related diseases: \$ _____,_____._____

Proof of Eagle-Picher product exposure must be enclosed. (See Instructions)

Please photocopy this page and list separately for each site, industry or occupation in which claimant alleges exposure to asbestos.

Date Exposure Began: _____/_____/_____ Date Exposure Ended: _____/_____/_____
(Month) (Day) (Year) (Month) (Day) (Year)

Occupation: _____

Description of Job Duties: _____

Industry in which exposure occurred: _____ If Code 37 (Other), specify: _____
(Code)

Industry Codes	
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. Eagle-Picher asbestos products manufacturing
20. Maritime	35. Non-Eagle-Picher asbestos products manufacturing/mining
21. Military	36. Building occupant/bystander
23. Non-asbestos products manufacturing	37. Other
24. Petrochemical	

Describe how and why Eagle-Picher product was used at the site:

Employer: _____

Site or Location of exposure: _____

Plant or Site Name: _____

Location at plant or site where exposure occurred: _____

City: _____ State: _____

Describe how injured party was exposed to Eagle-Picher product:

Name of Eagle-Picher product(s) to which injured party was exposed:

Part 5: Exposure to an Occupationally Exposed Person

Is the claimant alleging an asbestos-related disease resulting solely from exposure to an occupationally exposed person, such as a family member (spouse, father, sister, etc.)?

Yes: _____ No: _____

Name of Occupationally Exposed Person: _____

Date Exposure to Other Person Began: Month _____ Year _____

Date Exposure to Other Person Ended: Month _____ Year _____

Relationship to occupationally exposed individual:

I am his/her _____
(Brother, Son, Spouse, etc.)

Describe how injured party was exposed to the Eagle-Picher product:

***Part 4, page 5, must be completed for
the occupationally exposed person.**

Part 7: Asbestos Litigation

Has an asbestos-related lawsuit ever been filed on behalf of the injured party?

Yes: _____ No: _____

Two-letter abbreviation of the state in which the suit was originally filed:

Name of court in which suit was originally filed: _____

Date on which the suit was originally filed: _____
(Month/Year)

Date of Verdict	Name of Defendant(s)	Verdict Amount
_____ (Month / Year)	_____	\$ _____

Has injured party received settlement money from Eagle-Picher?

Yes: _____ No: _____

Please provide the Aggregate Settlement Amount received from all defendants: \$ _____

Part 8: Workers' Compensation/Other Disability Claims

Has the injured party ever received disability benefits related to asbestos?

Yes: _____ No: _____

Name of organization granting benefits: _____
(FECA, WC, etc.)

Date benefits began: _____/_____
(month) (year)

Monthly benefit stipend: \$ _____,_____._____

Name of company claim was filed against: _____

Does injured party claim disability related to asbestos even if no disability claim has been filed previously? Yes: _____ No: _____

If Yes, please explain and document: _____

Part 9: Employment Information

Current Employment Status:

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

Amount of last annual wage: \$ _____,_____._____

Date of last wage received: _____/_____

(month) (year)

*(enter current month and year if currently earning work-related compensation)***W-2 and first page of 1040 for last year of full employment must be enclosed if lost wages are being claimed.**

PART 10: 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).

I 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.

Signature of Claimant or Representative

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

Please review your submission to ensure it is complete.

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as requested in instructions
- Proof of Eagle-Picher product exposure as set out in instructions
- W-2 and first page of 1040 for last year of full employment