

UNR ASBESTOS-DISEASE CLAIMS TRUST
 East-West Tech Center 1771 W. Diehl Rd Suite 220 Naperville, IL 60563

PROOF OF CLAIM FORM

5. IF LAWSUIT HAS BEEN FILED AGAINST ANYONE FOR ASBESTOS RELATED DISEASE:	
Name of Court Where Filed:	Status of Case: <input type="checkbox"/> Pending <input type="checkbox"/> Inactive of Stayed <input type="checkbox"/> Closed
State Where Filed:	Total Amount Paid As Of This Date: \$ _____
Date Filed: _____ Year _____ Month _____ Day	
Case Number:	
6. HAVE YOU EVER FILED A CLAIM AGAINST THE MANVILLE TRUST? <input type="checkbox"/> Yes <input type="checkbox"/> No - Claim No. _____ Amount of Settlement \$ _____	
7. HAS THERE BEEN A WORKERS' COMPENSATION CLAIM FILED ON BEHALF OF DISEASED CLAIMANT? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, against whom _____	
8. ASBESTOS RELATED INJURY OR ILLNESS	
Condition:	Date of Diagnosis:
	Physician's Name Telephone Number (____) _____ - _____
Condition:	Date of Diagnosis:
	Physician's Name Telephone Number (____) _____ - _____
Condition:	Date of Diagnosis:
	Physician's Name Telephone Number (____) _____ - _____
Condition:	Date of Diagnosis:
	Physician's Name Telephone Number (____) _____ - _____
The following <i>must</i> be attached if available. Please check items submitted. A <input type="checkbox"/> Copy of radiologist's report (do not submit x-rays.) B <input type="checkbox"/> Copy of medical reports of all physicians listed above setting forth basis of diagnosis. C <input type="checkbox"/> All surgical, pathological and hospital reports supporting diagnosis. D <input type="checkbox"/> Death certificate for deceased claimant.	The following <i>would be helpful</i> in evaluating claims fairly. Please check items submitted. * <input type="checkbox"/> Executed medical release permitting Trust to obtain medical data from identified doctors. * <input type="checkbox"/> Authorization release of social security information regarding claimant's employment history. * <input type="checkbox"/> Authorization release of worker's compensation information regarding claimant's medical history. _____ Other _____ *(Blank Releases Attached)

