KEENE CREDITORS TRUST

PROOF OF CLAIM FORM
ASBESTOS RELATED PERSONAL INJURY CLAIMS

Submit completed claims to:
Claims Processing Facility, Inc.
East – West Tech Center
1771 West Diehl Rd, Suite 220
Naperville, IL 60563

Instructions for the Claim Form

Note: It is possible that claim data previously submitted to the Eagle Picher Industries Inc. Personal Injury Settlement Trust can be used to expedite the preparation and review of claims for the Keene Creditors Trust. Doing so will reduce the work necessary to file a claim and minimize the time it takes to review the claim. Please visit the Claims Processing Facility website (www.cpf-inc.com) for information on how to make use of this data.

Otherwise, 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 Keene Corporation Exposure as set out in the instructions
- Copy of cover sheet of complaint (if applicable – see Part 5 below)
- Copy of W-2 and first page of IRS Form 1040 (if applicable – see Part 8 below)

Choice of Claim Process
Please choose the applicable claim process **(check only one)**:

☐ Expedited Review (not available for Category 3 - Lung Cancer, Level I)
☐ Individual Review (only available for Category 3 - Lung Cancer, Level I)

Representation
If counsel represents claimant, please print or type the following information:

1. Attorney name: _____
(Last) (First) (MI)

2. Name of Law Firm: _____

3. Firm Address: _____

_____

4. Attorney Phone: ( ) _____ Fax: ( ) _____ Email: _____

5. Paralegal or Contact Name: _____
(Last) (First) (MI)

6. Contact Phone: ( ) _____ Fax: ( ) _____ Email: _____

7. Attorney's or Law Firm's Tax ID Number: _____

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

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

8b. Social Security Number: _____-____- _____

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

_____
(city/state/zip)

8d. Daytime Phone: ( ) _____ - _____

8e. Email Address: _____

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

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 listing of the specific medical criteria and records that must be enclosed for each Disease Category. **(Check only the most serious)**

	Category	Scheduled Disease
☐	1	Mesothelioma
☐	2	Lung Cancer, Level II
☐	3	Lung Cancer, Level I
☐	4	Other Cancer
☐	5	Severe Asbestosis Disease (ILO of 2/1 or greater, or asbestosis determined by pathology plus (a) TLC less than 65% or (b) FVC less than 65% plus FEVl/FVC ratio greater than 65%)

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 Claims Procedures. The presumptive medical criteria for the Disease Categories set forth above are included in the instructions.

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Part 3: Company Exposure and Significant Occupational Exposure

Proof of Keene Corporation Exposure must be enclosed as required by Asbestos Claims Procedures sections 5.2 and 5.4(b). (See instructions)

Please photocopy this page and list separately each company site, industry, or occupation where the injured party was exposed to respirable asbestos.

1. Name of Plant/Site of Exposure: _____

   City: _____ State: _____

2. Employer: _____

3. Date Exposure Began: _____/_____ Date Exposure Ended: _____/_____
   (month) (year) (month) (year)

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

   _____

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

Industry Codes

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

6. Name of Keene asbestos-containing product(s) to which the injured party is alleging exposure:

_____

_____

7. Indicate circumstances of exposure (check all applicable):

☐ Claimant handled raw asbestos fibers on a regular basis

☐ Claimant fabricated asbestos-containing products such that the claimant in the fabrication process was exposed on a regular basis to raw asbestos fibers

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

☐ Claimant was employed in an industry or occupation such that the claimant worked on a regular basis in close proximity to workers who did one or more of the above three activities

☐ None of the above

8. Describe the circumstances of exposure supporting the answers to question 7 above:

_____

_____

Please provide independent documentation of meaningful and credible evidence of exposure to asbestos-containing products manufactured by Keene. This may be established by the original signature of the Claimant him or herself on this claim form made under penalty of perjury. In addition, this may be established by:

- **An affidavit of a co-worker**
- **An affidavit of a family member in the case of a deceased claimant**
- **Invoices**
- **Construction or similar records**

Part 4: Exposure to an Occupationally Exposed Person (Bystander)

Note: The following information will only be considered if mesothelioma is being alleged.

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. Name of occupationally exposed individual: _____
   (Last) (First) (MI)

5. Relationship to occupationally exposed individual:

   I am his/her _____.
   (brother, son, spouse, etc.)

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

7. Describe how injured party was exposed to the Keene product:

_____

_____

_____

_____

Reminder: Part 3 must be completed for the occupationally exposed person.

Part 5: Litigation/Claims History

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

2. State in which the suit was originally filed: _____

3. Name of court in which the suit was originally filed:_____

4. Case number:_____

5. Date the suit was originally filed:_____/_____
(month) (year)

6. What is the current status of this suit? ☐ Withdrawn/dismissed ☐ Judgment
☐ Pending ☐ Settled for payment

Please attach a photocopy of the endorsed cover sheet of the filed complaint.

Please proceed to Part 9: Signature Page if claimant is not requesting Individual Review. Individual Review may only be requested for claims alleging Category 3 -Lung Cancer, Level I. If Individual Review is requested, Parts 6, 7 and 8 must be completed.

Part 6: Financial Dependents and Beneficiaries

Note: The following information must be provided if requesting Individual Review. Individual Review may only be requested for Category 3 - Lung Cancer, Level I claims.

List any other persons who may have rights associated with this claim. Be sure to include the injured party's spouse and/or any other financial dependents who derive (or who derived 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 additional space is required, please photocopy this page and insert after current page.

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Other ______________________
4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Other ______________________
4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Other ______________________
4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Other ______________________
4. Financially Dependent: ☐ Yes ☐ No

Part 7: Smoking and Disease History

Note: The following information must be provided if requesting Individual Review. Individual Review may only be requested for Category 3 - Lung Cancer, Level I claims.

For each item, indicate whether injured party has smoked. Please indicate the dates they 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.

1. Has the injured party ever **Smoked Cigarettes?** Yes_____ No_____

1a. From: _____/_____ To: _____/_____
(month) (year) (month) (year)

1b. Packs per day:_____ (use decimal)

1. Has the injured party ever **Smoked Cigars?** Yes_____ No_____

1a. From: _____/_____ To: _____/_____
(month) (year) (month) (year)

1b. Cigars per day:_____ (use decimal)

Part 8: Employment Information for Economic Loss

Note: The following information must be provided if requesting Individual Review. Individual Review may only be requested for Category 3 - Lung Cancer, Level I claims.

1. 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
- ☐ Deceased

2. Amount of last annual wages: $_____

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

(Enter current month and year if currently earning work-related compensation.)

A W-2 and first page of Form 1040 for last year of full employment must be enclosed if lost wages are being claimed.

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). Note that in order for this claim form to constitute evidence of company exposure as set forth in Part 3 of this claim form, this claim form must be personally signed by the claimant; otherwise other evidence of company exposure of the type set forth in Part 3 must be submitted.

I have reviewed the information submitted on this claim form and all documents submitted in support of this claim. I declare under penalty of perjury that the foregoing is true and correct.

Executed on _____/_____/_____
(month) (day) (year)

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 and includes the following documents as applicable.

- ☐ Death Certificate (if applicable)
- ☐ Certificate of Official Capacity (if personal representative is filing form)
- ☐ Medical Records as required by the Asbestos Claim Procedures and as requested in the instructions
- ☐ Proof of Company Exposure and Significant Occupational Exposure as required in the Asbestos Claim Procedures and requested in the instructions.
- ☐ Cover sheet of filed complaint (if Part 5 is applicable)
- ☐ W-2 and first page of IRS form 1040 (if Part 8 is applicable)