UNR ASBESTOS-DISEASE CLAIMS TRUST

Revised 10/15/2014

East-West Corporate Center, 1771 W. Diehl Rd., Suite 220, Naperville, IL 60563

PROOF OF CLAIM FORM

1. IDENTIFICATION OF PERSON WITH ASBESTOS DISEASE:	**2. DEPENDENTS:**
Name:	Spouse's Name:
Current Street Address:	Current Street Address:
City State Zip	City State Zip
Telephone Number: _____ (Home) _____ (Work)	Dependent Name: Date of Birth: _____/_____/_____
Social Security No: If Deceased, Date of Death: _____ - _____ - _____ _____/_____/_____	Relationship: Parent _____ Child _____ Other
Date of Birth: Age: Married? _____/_____/_____ _____ _____ Yes _____ No	Dependent Name: Date of Birth: _____/_____/_____
3. IF PERSON WITH ASBESTOS DISEASE IS DECEASED:	Relationship: Parent _____ Child _____ Other _____
Name of Person Filing Claim:	Dependent Name: Date of Birth: _____/_____/_____
Current Street Address:	Relationship: Parent _____ Child _____ Other _____
City State Zip	Dependent Name: Date of Birth: _____/_____/_____
Social Security No: Date of Birth: _____ - _____ - _____ _____/_____/_____	Relationship: Parent _____ Child _____ Other
Relationship to Decedent:	

4. ATTORNEY REPRESENTING CLAIMANT	
Name of Attorney:	Current Street Address:
Law Firm Name:	City State Zip
Telephone Number: (_____) _____ - _____	

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5. IF LAWSUIT HAS BEEN FILED AGAINST ANYONE FOR ASBESTOS RELATED DISEASE:

Name of Court Where Filed:	Status of Case: _____Pending _____Inactive or Stayed _____ Closed
State Where Filed:	Total Amount Paid As Of This Date: $_____
Date Filed: _____ Year _____ Month _____ Day	
Case Number:	

6. HAS THERE BEEN A WORKERS' COMPENSATION CLAIM FILED ON BEHALF OF DISEASED CLAIMANT?

_____Yes _____No If yes, against whom _____

7. 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 *must* be attached if available.
Please check items submitted.

A _____ Copy of radiologist's report (do not submit x-rays.)
B _____ Copy of medical reports of all physicians listed above setting forth basis of diagnosis.
C _____ All surgical, pathological and hospital reports supporting diagnosis.
D _____ Death certificate for deceased claimant.

The following *would be helpful* in evaluating claims fairly.
Please check items submitted.

_____ Executed medical release permitting Trust to obtain medical data from identified doctors.
_____ Authorization release of social security information regarding claimant's employment history.
_____ Authorization release of worker's compensation information regarding claimant's medical history.

_____ Other _____

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Social Security No. of Person with Asbestos Disease: _____ - _____ - _____

8. EXPOSURE TO ANY AND ALL ASBESTOS PRODUCTS*: (If additional space is needed, attach list and specify as "additional asbestos exposure")*:

Date(s) of Exposure(s) ***From*** ***To***	***Location*** *(Specific - Shipyard, Company, Factory site, Government branch [Army, Navy, etc].* ***Please specify every location known where claimant has been exposed to any asbestos product of any manufacturer.***	***Trade or Job Classification –*** please be as descriptive of job duties as space will allow – add attachment if necessary	***Products Exposed to***. For UNR products, please be specific. Exposure to the products of other manufacturer's is assumed at any site listed, unless specifically explained. If no UNR products were at any of the sites listed, indicate products as "other"

9. CLAIMANT'S SIGNATURE: (All claims must be signed by claimant or his/her representative.)

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION CONTAINED IN THIS PROOF OF CLAIM IS TRUE AND COMPLETE, AND IS SUBMITTED TO THE UNR TRUST WITH A DECLARATION OF ITS ACCURACY UNDER PENALTY FOR PRESENTATION OF A FRAUDULENT CLAIM IN ACCORDANCE WITH TITLE 18 U.S.C., § 152.

Signature of Claimant or Attorney
Representing Claimant

Name of Claimant or Attorney
Representing Claimant