BLUE CLAIM FORM FOR LIEN RESOLUTION

A. PRODUCT USER'S INFORMATION

1. Name	Last: Doe		First: Jane	Middle Initial: L
2. Date of Birth	11 / 27 / 1969 (MM/DD/YYYY)	**3. Social Security Number**	| 9 | 8 | 7 | - | 7 | 9 | - | 9 | 1 | 9 | 8 |	

B. LEGAL REPRESENTATIVE'S INFORMATION FOR DECEASED OR INCAPACITATED PRODUCT USER

4. Does the Product User have a Legal Representative?		☐ Yes If Yes, complete Item 5. ☒ No If No, skip to Item 6.	
5. Legal Representative's Name	Last:	First:	Middle Initial:

C. PRODUCT USE INFORMATION

6. Did the Revision Surgery occur at a hospital located in the United States?	☒ Yes ☐ No

D. INSURANCE IDENTIFICATION

Instructions: Identify all insurers and third party payor(s) of medical expenses since the date of implant by filling out the table below. If you did not have insurance since the date of implant, check Uninsured and proceed to Section E. By way of example, this can include (but is not limited to): private insurance; insurance provided through an employer, union or other benefit plan; insurance or coverage provided through a spouse's insurance or employment; workers compensation; traditional Medicare (Parts A and B); private insurers providing Medicare Part C coverage ("Medicare Advantage"); private insurers providing Medicare Part D (prescription drug) benefits; Medicare supplemental or "MediGap" insurance; and/or other government payor programs such as Medicaid, CHAMPVA, TRICARE, and the Indian Health Service. Identify the nature of the insurer(s) or third party payer(s), such as (but not limited to) traditional Medicare; Medicare Part C ("Medicare Advantage"); employer-sponsored plan; spouse's employer-sponsored plan; spouse's insurance; workers compensation benefit; private insurance; Medicare supplemental ("MediGap"); other government program.

☐ Uninsured

To assist in the accurate and timely processing of lien resolution, provide all requested information for each insurer or third party payor identified in the table below. If you have a copy of the insurance card from a listed insurer or payer, include a copy of that card with this Blue Form.

Insurer/Plan Name	**Policy/Plan Number**	**Dates of Coverage/ Eligibility**	**Policyholder/ Subscriber Name**	**Coverage Description** (Primary/Secondary/ Supplemental)	**Nature of Insurer or Third Party Payor** (*e.g.*, Medicare, Medicare Advantage, Medigap, etc.)
Anthem	123456789	06/07/2004 TO 12/31/2012	Jane L Doe	Primary	
BlueCross BlueShield of NM	0987654321	01/01/2013 TO		Primary	John W Doe

7. Has health insurance since date of implant included a plan provided through an employer (including through the spouse's employment)?	☒ Yes ☐ No	If Yes, include employer name(s) and date(s) of employment in the table below. Include spouse's employer if applicable. If you are unclear whether the insurance was provided through an employer, provide the employer name and dates of employment.

Employer Name	Dates of Employment
ABC Corp	6 / 2004 (MM/YYYY) **TO** 12 / 2012 (MM/YYYY)
	___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)
	___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)
	___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)

E. LIEN CORRESPONDENCE

Instructions: Indicate whether the Product User (or Legal Representative) is aware of, or has received correspondence concerning, alleged liens, claims, or reimbursement interests related to a Qualified Device, Revision Surgery or Settlement. Provide information related to, and copies of, all correspondence or notices to/from, or on behalf of, any insurer, payor, healthcare provider, recovery contractor, or other entity concerning liens, claims, interests or reimbursement allegedly related to a Qualified Device, Revision Surgery, or Settlement. Also, provide any lien correspondence that is received after the date this Claim Form is submitted.

8.	**Is the Product User (or Legal Representative) aware of any alleged liens?**	☐ Yes ☒ No	If Yes, provide copies/information relating to lien(s).
9.	**Has the Product User (or Legal Representative) received or sent any correspondence concerning reimbursement or alleged liens?**	☐ Yes ☒ No	If Yes, provide copies.
10.	**Provide an explanation of any additional circumstances regarding liens.**		

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F. RESIDENCE

Instructions: Identify state(s) of residence of the Product User (and the policyholder, if different) since date of implant and dates of duration of such residence. If the Product User or Policyholder has resided in the same state since the date of the ASR Index Surgery, check the box in the far right column.

Resident	State	Duration of Residence	Product User/Policyholder has Resided in this Same State Since His/Her ASR Index Surgery
☒ Product User ☐ Policyholder	NM	1 / 1999 (MM/YYYY) **TO** ___/____ (MM/YYYY)	☒
☐ Product User ☐ Policyholder		___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)	☐
☐ Product User ☐ Policyholder		___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)	☐
☐ Product User ☐ Policyholder		___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)	☐
☐ Product User ☐ Policyholder		___/___ (MM/YYYY) **TO** ___/___ (MM/YYYY)	☐

G. CERTIFICATION BY CLAIMANT

I declare under penalty of perjury under 28 U.S.C. §1746 that all of the information provided in and with this Claim Form is true and correct to the best of my knowledge, information and belief.

I acknowledge and understand that DePuy's specific lien resolution responsibilities are stated in the Settlement Agreement.

Claimant's Signature			**Date**	_____/_____/_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	

H. COUNSEL SIGNATURE

Counsel's Signature			**Date**	_____/_____/_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	