RED CLAIM FORM FOR BILATERAL AWARD

The Claims Package and Required Submissions, including this Red Claim Form, must be submitted no later than April 1, 2014, on behalf of Enrolled Program Claimants, including Unrepresented (*pro se*) Enrolled Program Claimants in the U.S. Program outlined in the Settlement Agreement of November 19, 2013 (the "Agreement"), who have undergone ASR Revision Surgery in both hips. A Claimant submitting this Red Claim Form must also submit an Orange Claim Form for Part A Base Payment.

If a claimant has had a revision of more than one ASR Hip Implant in a single hip (Re-Revision) or otherwise qualifies for compensation from the Extraordinary Injury Fund, the Claimant must submit a Green Claim Form, in addition to an Orange Claim Form, to receive Extraordinary Injury Benefits.

INSTRUCTIONS

1. Counsel for Claimants, and all *pro se* Claimants who seek compensation for having undergone an ASR Revision Surgery in both hips must complete this Claim Form.

2. A "Claimant" as referred to in this Claim Form means the individual submitting a claim in the U.S. Program, who is either the Product User or the Legal Representative, as defined in 1.2.44 of the Agreement.

A. PERSONAL INFORMATION OF PRODUCT USER

1. Name	Last: DOE		First: JANE	Middle Initial: L
2. Date of Birth	11 / 27 / 1969 (MM/DD/YYYY)	**3. Social Security Number**	987-79-9198	
4. Was the Product User a citizen or legal resident of the United States at the time of the Index Surgery to implant the ASR Hip Implant in the Bilateral Hip?	☒ Yes ☐ No			

B. PRIMARY LAW FIRM INFORMATION (if represented by an attorney)

5. Principal Responsible Attorney	Last: John	First: Smith	Middle Initial:
6. Firm Name	Law Firm 1		
7. Current Address	Street:		
	City:	State:	Zip:
8. Telephone Number	(___) ___ - ____		
9. Fax Number	(___) ___ - ____		
10. Email Address			

C. BILATERAL AWARD CLAIM INFORMATION

Check the ASR Hip Implants and Other Circumstances that apply to the Product User's Bilateral use of ASR Hip Implants and indicate the date(s) of occurrence.

If a Claimant has had a revision of an ASR in both hips, the Claimant must submit an Orange Claim Form for the first hip revised and this Red Claim Form for Bilateral benefits. If a Claimant has had a revision of more than one ASR in a single hip, the Claimant must submit an Orange Claim Form for the first revision and a Green Claim Form for Re-Revision benefits.

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LEFT HIP

11. Indicate the Product Implanted into the Product User		☐ **Total Hip Replacement with ASR XL Hip Implant** ☒ **ASR Hip Resurfacing Implant**	
12. Date of Index Surgery	2 / 6 / 2012 (MM/DD/YYYY)	**13. Location of Hospital Where Index Surgery Occurred**	☒ Hospital Located in the U.S. ☐ Military Hospital Located Outside of the U.S. ☐ Non-Military Hospital Located Outside of the U.S.
14. Name of Hospital Where Index Surgery Occurred	Albuquerque Medical Center		
15. Name of Index Surgery Surgeon	Last: Smith	First: Tom	Middle Initial:
16. Did the Product User undergo a Revision Surgery involving the Left ASR Hip Implant?	☒ Yes ☐ No	If Yes, complete Items 49 thru 52. If No, skip to Item 53.	
17. Date of Revision Surgery	1 / 31 / 2013 (MM/DD/YYYY)	**18. Location of Hospital Where Revision Surgery Occurred**	☒ Hospital Located in the U.S. ☐ Military Hospital Located Outside of the U.S. ☐ Non-Military Hospital Located Outside of the U.S.
19. Name of Hospital Where Revision Surgery Occurred	Albuquerque Medical Center		
20. Name of Revision Surgery Surgeon	Last: Smith	First: Tom	Middle Initial:

RIGHT HIP

21. Indicate the Product Implanted into the Product User		☐ **Total Hip Replacement with ASR XL Hip Implant** ☐ **ASR Hip Resurfacing Implant**	
22. Date of Index Surgery	___/ ___/ ___ (MM/DD/YYYY)	**23. Location of Hospital Where Index Surgery Occurred**	☐ Hospital Located in the U.S. ☐ Military Hospital Located Outside of the U.S. ☐ Non-Military Hospital Located Outside of the U.S.
24. Name of Hospital Where Index Surgery Occurred			
25. Name of Index Surgery Surgeon	Last:	First:	Middle Initial:

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26. Did the Product User undergo a Revision Surgery involving the RightASR Hip Implant?	☐ Yes ☐ No	If Yes, complete Items 59 thru 62. If No, skip to Item 63.

27. Date of Revision Surgery	___/ ___/ ___ (MM/DD/YYYY)	**28. Location of Hospital Where Revision Surgery Occurred**	☐ Hospital Located in the U.S. ☐ Military Hospital Located Outside of the U.S. ☐ Non-Military Hospital Located Outside of the U.S.

29. Name of Hospital Where Revision Surgery Occurred			
30. Name of Revision Surgery Surgeon	Last	First	Middle Initial

D. REQUIRED SUBMISSIONS

You must submit all materials required by Section 4.1.3 of the Agreement:

- ☐ The Orange Claim Form for Part A Base Benefits (along with all necessary attachments).
- ☐ This Red Claim Form for Bilateral Award.
- ☐ Manufacturer/product stickers for the Qualifying ASR, identifying Product and Lot Codes for the Bilateral device implanted into the Product User.
- ☐ A true and correct copy of all Contemporaneous Medical Records identifying the Bilateral ASR XL Acetabular Hip Systems, ASR 300 Acetabular Cup Systems, or ASR Resurfacing Systems that were surgically implanted in the Product User in an ASR Index Surgery and removed during a Revision Surgery. This includes all records in your possession and obtained as a result of ordering the records.
- ☐ A true and correct copy of the Contemporaneous Medical Records, including Admission Records (including History and Physical Examination Records), Discharge Summaries, Anesthesia Record and Operative Reports pertaining to any Bilateral ASR Index Surgery and ASR Revision Surgery.

E. 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 further certify that by participating in this U.S. Program, I agree to abide by the terms of the Agreement, and further understand that by enrolling in the Settlement Program, I agree to be bound by the terms of MDL Case Management Order 13, as amended, which permits a holdback of 5% fees and 1% costs to be deducted from any final award/gross recovery to me from the U.S. Program which shall be used, in part, for the funding of the administration of the U.S. Program. I further agree to comply with any Orders entered by the United States District Court for the Northern District of Ohio (MDL Docket No. 1:10-md-2197) in the furtherance of Case Management Order 13, and consent to the jurisdiction of that MDL Court for that purpose. I further grant and convey to the Settlement Oversight Committee for MDL 2197 a lien upon and/or security interest for such holdback amounts in any recovery by me from the U.S. Program. If I qualify for a settlement payment pursuant to the terms of the Agreement, I authorize such settlement payment to be made to my Counsel identified as my Primary Law Firm in trust for me in accordance with the Agreement.

Claimant's Signature		**Date**	____/_____/_____ (MM/DD/YYYY)

Printed Name	First	Middle Initial	Last

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F. COUNSEL SIGNATURE

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