ORANGE CLAIM FORM FOR PART A BASE AWARD

The Claims Package and Required Submissions, including this Orange Claim Form, must be submitted no later than April 1, 2014, on behalf of all 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").

If a Product User has had an ASR Revision Surgery in both hips, the Product User or Legal Representative must submit this Orange Claim Form and a Red Claim Form for Bilateral benefits. If a Product User 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 Product User or Legal Representative must submit this Orange Claim Form and also a Green Claim Form. All U.S. Program Claimants must also submit a Blue Claim Form for lien resolution to: (1) identify any liens, claims, interests or requests for reimbursement that are allegedly related to an ASR or ASR Revision Surgery, or (2) state that they are aware of no such liens or claims.

INSTRUCTIONS

1. Counsel for Claimants, and all *pro se* Claimants, 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. Current Address	Street:		
	City: Santa Fe	State: NM	Zip:	Country: United States of America
3. Date Began Residing at this Address	___/___/___ (MM/DD/YYYY)	☒ **Product User has resided at this same address since his/her ASR Index Surgery**	
4. Telephone Number	(___) ___-___	**5. Date of Birth**	11 / 27 / 1969 (MM/DD/YYYY)
6. Social Security Number	987-79-9198	**7. Gender**	☐ Male ☒ Female

8. Any Other Names Used or by which the Product User has been known, including but not limited to maiden name:

JANE SMITH

9. 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(s)?	☒ Yes ☐ No

B. LEGAL REPRESENTATIVE'S INFORMATION FOR DECEASED OR INCAPACITATED PRODUCT USERS (COURT APPROVAL OR OTHER AUTHORIZATION TO REPRESENT THE PRODUCT USER MUST BE ATTACHED)

10. Does the Product User have a Legal Representative?	☐ Yes ☒ No — If Yes, complete Items 11-17. If No, skip to Item 18.
11. Reason for Legal Representative	☐ Product User is Deceased ☐ Product User is Incompetent

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12. Legal Representative's Relationship to Product User	☐ Estate ☐ Executor ☐ Administrator ☐ Guardian ☐ Conservator ☐ Other _____ (specify)			
13. Legal Representative's Name	Last		First	Middle Initial
14. Legal Representative's Address	Street			
	City	State	Zip	Country
15. Legal Representative's Social Security Number	___-___-___			
16. Date of Death of Product User (if applicable)	___/___/___ (MM/DD/YYYY)			
17. Do you claim the ASR Revision Surgery caused the death?	☐ Yes ☐ No ☐ N/A			

C. PRIMARY LAW FIRM INFORMATION (IF REPRESENTED BY AN ATTORNEY)

18. Principal Responsible Attorney	Last JOHN		First SMITH	Middle Initial
19. Firm Name	Law Firm 1			
20. Current Address	Street			
	City	State	Zip	
21. Telephone Number	(___) ___-___			
22. Fax Number	(___) ___-___			
23. Email Address				
24. Date of Retention Agreement with Claimant/Plaintiff	11 / 10 / 2013 (MM/DD/YYYY)			

D. LAWSUIT AND PLAINTIFF INFORMATION

25. Has a civil action been filed in court alleging injuries as a result of the Product User's Revision Surgery involving an ASR Hip Implant?	☐ Yes ☒ No	If Yes, complete Items 26-34, as applicable. If No, skip to Item 35.
26. Current Court/Jurisdiction		
27. Case Caption		
28. Case Number		

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29. Is the Plaintiff in the civil action the same individual as the Product User identified in Section A or the Legal Representative identified in Section B of this Claim Form?			☐ Yes ☐ No	If Yes, skip to Item 35. If No, complete Items 30-34.
30. Plaintiff's Name	Last	First		Middle Initial
31. Plaintiff's Address	Street			
	City	State	Zip	Country
32. Plaintiff's Telephone Number	( ) -			
33. Plaintiff's Social Security Number	- -			
34. Plaintiff's Relationship to Product User	☐ Estate ☐ Executor ☐ Administrator ☐ Guardian ☐ Conservator ☐ Other _____ (specify)			

E. SPOUSE INFORMATION

35. Is the Product User currently married?			☒ Yes ☐ No	If Yes, complete Items 36-39. If No, skip to Item 40.
36. Spouse's Name	Last DOE	First JOHN		Middle Initial
37. Spouse's Date of Birth	____/____/____ (MM/DD/YYYY)	**38. Spouse's Social Security Number**	- -	
39. What is the status of the Product User's current relationship with his/her spouse?		☐ Live Together ☐ Separated ☐ Estranged		
40. If the Product User is not currently married, was he/she married at any time from the date of the ASR Index Surgery until November 18, 2013?			☐ Yes ☐ No	If Yes, complete Items 41 and 42. If No, skip to Item 43.
41. Former Spouse's Name	Last	First		Middle Initial
42. Select the reason the Product User is no longer married.	☐ Divorced ☐ Death of former spouse ☐ Death of Product User			

F. BASE AWARD CLAIM INFORMATION

Check the ASR Hip Implants and Other Circumstances that apply to the Product User's 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 this Orange Claim Form for the first hip revised and a 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 this Orange Claim Form for the first revision and a Green Claim Form for Re-Revision benefits.

LEFT HIP

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43. Indicate the Product Implanted into the Product User		☐ **Total Hip Replacement with ASR XL Hip Implant** ☐ **ASR Hip Resurfacing Implant**	
44. Date of Index Surgery	___/___/___ (MM/DD/YYYY)	**45. 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.
46. Name of Hospital Where Index Surgery Occurred			
47. Name of Index Surgery Surgeon	Last	First	Middle Initial
48. 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.
49. Date of Revision Surgery	___/___/___ (MM/DD/YYYY)	**50. 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.
51. Name of Hospital Where Revision Surgery Occurred			
52. Name of Revision Surgery Surgeon	Last	First	Middle Initial

RIGHT HIP

53. Indicate the Product Implanted into the Product User		☒ **Total Hip Replacement with ASR XL Hip Implant** ☐ **ASR Hip Resurfacing Implant**	
54. Date of Index Surgery	2 / 2 / 2010 (MM/DD/YYYY)	**55. 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.
56. Name of Hospital Where Index Surgery Occurred	Santa Fe General Hospital		
57. Name of Index Surgery Surgeon	Last JONES	First BOB	Middle Initial
58. Did the Product User undergo a Revision Surgery involving the Right ASR Hip Implant?		☒ Yes ☐ No	If Yes, complete Items 59 thru 62. If No, skip to Item 63.

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59. Date of Revision Surgery	3 / 3 / 2011 (MM/DD/YYYY)	**60. 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.
61. Name of Hospital Where Revision Surgery Occurred	Santa Fe General Hospital		
62. Name of Revision Surgery Surgeon	Last: JONES	First: BOB	Middle Initial:

G. BANKRUPTCY INFORMATION

63. Has the Product User at any time since the date of the ASR Index Surgery been party to a bankruptcy action in which he/she is seeking bankruptcy protection?	☐ Yes ☒ No	If Yes, complete Items 45-49. If No, skip to Section H.
64. Bankruptcy Court/ Jurisdiction		
65. Case Number		**66. Date Filed** ___/ ___/ ____ (MM/DD/YYYY)
67. Trust Name (If Trustee appointed.)		
68. Status of Bankruptcy Filing	☐ Open ☐ Closed (If closed, provide the date closed.) ___/ ___/ ___ (MM/DD/YYYY)	

H. REQUIRED SUBMISSIONS

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

☐ Enrollment Form.

☐ Release.

☐ Dismissal with Prejudice Stipulation (if applicable).

☐ This Orange Claim Form.

☐ Manufacturer/product stickers for the Qualifying ASR, identifying Product and Lot Codes for the device implanted into the Product User.

☐ A true and correct copy of all Contemporaneous Medical Records identifying the ASR XL Acetabular Hip System, ASR 300 Acetabular Cup System, or ASR Resurfacing System that was 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.

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☐ 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 ASR Index Surgery and ASR Revision Surgery.

☐ A medical record showing your weight and height at your ASR Index Surgery and your smoking status at the time of your ASR Revision Surgery.

I. 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 award 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		

J. COUNSEL SIGNATURE

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