# RED CLAIM FORM FOR BILATERAL AWARD

The Claims Package and Required Submissions, including this Red Claim Form, must be submitted no later than May 5, 2017, on behalf of Enrolled Program Claimants, including Unrepresented (*pro se*) Enrolled Program Claimants in the U.S. Program outlined in the Settlement Agreement of March 2, 2015 (the "2015 Agreement") and the 2017 ASR Extension Agreement dated March 3, 2017, ("the 2017 Extension Agreement") (generally and collectively referred to herein as the "U.S. Program"), 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. Any references to the 2015 Agreement in this Red Claim Form incorporate the terms detailed in the 2017 Extension Agreement in addition to those of the 2015 Agreement.

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 1.2.43 of the 2015 Agreement.

## A. PERSONAL INFORMATION OF PRODUCT USER

| | | | | |
|---|---|---|---|---|
| **1. Name** | Last | | First | Middle Initial |
| **2. Date of Birth** | ____/____/____ (MM/DD/YYYY) | **3. Social Security Number** | \|_\|_\|_\|_\| - \|_\|_\| - \|_\|_\|_\|_\| | |
| **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 | First | Middle Initial |
| **6. Firm Name** | | | |
| **7. Current Address** | Street | | |
| | City | State | Zip |
| **8. Telephone Number** | (_\|_\|_) \|_\|_\|_\|_\| - \|_\|_\|_\|_\| | | |
| **9. Fax Number** | (_\|_\|_) \|_\|_\|_\|_\| - \|_\|_\|_\|_\| | | |
| **10. Email Address** | | | |

## C. BILATERAL AWARD CLAIM INFORMATION

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**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.

## LEFT HIP

| | |
|---|---|
| **11. Indicate the Product Implanted into the Product User** | ☐ **Total Hip Replacement with ASR XL Hip Implant**<br>☐ **ASR Hip Resurfacing Implant** |

| | | | |
|---|---|---|---|
| **12. Date of Index Surgery** | __/_____/_____<br>(MM/DD/YYYY) | **13. Location of Hospital Where Index Surgery Occurred** | ☐ Hospital Located in the U.S.<br>☐ Military Hospital Located Outside of the U.S.<br>☐ Non-Military Hospital Located Outside of the U.S. |

| | | | |
|---|---|---|---|
| **14. Name of Hospital Where Index Surgery Occurred** | | | |
| **15. Name of Index Surgery Surgeon** | Last | First | Middle Initial |

| | | |
|---|---|---|
| **16. Did the Product User undergo a Revision Surgery involving the Left ASR Hip Implant?** | ☐ Yes ☐ No | If Yes, complete Items 17 – 20.<br>If No, skip to Item 21. |

| | | | |
|---|---|---|---|
| **17. Date of Revision Surgery** | __/_____/_____<br>(MM/DD/YYYY) | **18. Location of Hospital Where Revision Surgery Occurred** | ☐ Hospital Located in the U.S.<br>☐ Military Hospital Located Outside of the U.S.<br>☐ Non-Military Hospital Located Outside of the U.S. |

| | | | |
|---|---|---|---|
| **19. Name of Hospital Where Index Revision Occurred** | | | |
| **20. Name of Revision Surgery Surgeon** | Last | First | Middle Initial |

## RIGHT HIP

| | |
|---|---|
| **21. Indicate the Product Implanted into the Product User** | ☐ **Total Hip Replacement with ASR XL Hip Implant**<br>☐ **ASR Hip Resurfacing Implant** |

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| | | | |
|---|---|---|---|
| **22. Date of Index Surgery** | _____/_____/_____ (MM/DD/YYYY) | **23. Location of Hospital Where Index Surgery Occurred** | ☐ Hospital Located in the U.S.<br>☐ Military Hospital Located Outside of the U.S.<br>☐ 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 |
| **26. Did the Product User undergo a Revision Surgery involving the Right ASR Hip Implant?** | ☐ Yes ☐ No | If Yes, complete Items 27 – 30.<br>If No, skip to Section D. | |
| **27. Date of Revision Surgery** | _____/_____/_____ (MM/DD/YYYY) | **28. Location of Hospital Where Revision Surgery Occurred** | ☐ Hospital Located in the U.S.<br>☐ Military Hospital Located Outside of the U.S.<br>☐ 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 2015 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, and Operative Reports pertaining to any Bilateral ASR Index Surgery and ASR Revision Surgery.

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## 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 2015 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 2015 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 2015 Agreement.

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

## F. COUNSEL SIGNATURE

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