IN RE: PROPULSID® PRODUCTS LIABILITY LITIGATION

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

MDL NO. 1355

RESOLUTION PROGRAM

CLAIM FORM
FOR ALLEGED PERSONAL INJURY

TIER II – Non-Fatal Cardiac Arrest
or
TIER III – Primary Tachycardic Ventricular Arrhythmia

TO BE COMPLETED BY PLAINTIFF OR CLAIMANT (WITH OR WITHOUT ASSISTANCE OF COUNSEL)

I.
CATEGORY OF CLAIM:

YOU MUST CHECK OFF ONLY ONE BOX BELOW FOR THE CATEGORY OF CLAIM YOU ARE MAKING:

TIER II: NON-FATAL CARDIAC ARREST _____

OR

TIER III: PRIMARY TACHYCARDIC VENTRICULAR ARRHYTHMIA _____

II.
AGREEMENT AND INSTRUCTIONS

A. This form is to be used for submitting alleged personal injury claims by or on behalf of any Propulsid® Plaintiff in a lawsuit filed in or removed to Federal Court before February 1, 2004, which was then pending in the MDL 1355 Court or was in the course of being transferred or hereafter is transferred to the MDL 1355 Court by the MDL Panel (hereafter, "Plaintiff"), or by or on behalf of any Propulsid® claimant on a signed Tolling Agreement (including Plaintiffs in the Master Complaint of Louisiana Propulsid® Claimants, known as the Achord action, filed in the USDC, E. Dist. of LA) (hereafter, "Claimant") who has timely enrolled in the Propulsid® MDL 1355 Resolution Program (hereafter, the "Program") as described in the MDL 1355 Term Sheet dated April 30, 2004, which is incorporated herein in its entirety.

B. To properly submit this Claim Form, read the Claim Form in its entirety and answer all of the inquiries in it on the Claim Form itself [and add additional sheets if necessary] and then sign and date the Claim Form and complete a Certificate of Service of the Claim Form for Personal Injury in a form like that in the template Certificate of Service set forth in Attachment B; and:

C. It is recognized that there may be conditions which prevent you from providing all the information sought in this claim form and in providing all the required medical records. However, your vigorous diligence in providing that information and in providing those records is required. The Medical Review Panel has the discretion to approve or deny your claim based on the information that you submit.

D.. Serve complete copies of:

- the completed, signed and dated Claim Form;

- the signed and dated Certificate of Service of Claim Form for Personal Injury describing the manner of service as follows:

(a) one copy to Liaison Counsel for Plaintiffs' Steering Committee:

Russ M. Herman, T.A.
Herman, Mathis, Casey, Kitchens & Gerel, LLP
820 O'Keefe Avenue
New Orleans, LA 70113
Phone: (504) 581-4892
Fax: (504) 561-6024

(b) the original to Lead Counsel for Defendants:

Thomas F. Campion, Esq. and
Charles F. Preuss, Esq.
Drinker, Biddle & Reath LLP
50 Fremont Street, 20th Floor
San Francisco, CA 94105-2235
Phone: (415) 591-7500
Fax: (414) 591-7510

E.. You must submit this Claim Form and serve it in the manner described below within 120 days of service of notice by Plaintiffs' Steering Committee ("PSC") that the Program's minimum enrollment levels have been reached, or 120 days after serving your Enrollment Form, whichever is later.

F. You will have 60 days after service of your Claim Form to serve the medical records satisfying the 'medical records requirements' set forth in Section 2 of Exhibit A to the Term Sheet (unless pursuant to Section 7 of the Term Sheet, upon application to the Special Master, you have demonstrated a good faith effort to secure the medical records, then the period for securing records shall be extended for an additional 60 days. (see Attachment A to this Claim Form for a description of the 'medical records requirements' contained in Section 2 of Exhibit A to the Term Sheet.)

G. If you fail to submit the medical records required to process your claim within 60 days after you serve your Claim Form, then subject to the exception in Section 7 of the Term Sheet allowing for an additional 60 days to secure records upon a showing of good faith effort to secure the records (made by application to the Special Master), your claim shall be dismissed with prejudice in its entirety. No further action is to be taken on it and no litigation may be commenced or maintained to attempt to pursue that or any other Propulsid®-related claim.

H. If your claim is a Tier II claim for personal injury based on an alleged non-fatal cardiac arrest (see Exhibit A to Term Sheet, Section 2, 'Settlement Categories' – Tiers I and II), then within 60 days of service of your medical records (and no later than 120 days from service of your Claim Form), you may also serve on the medical panel a confidential memorandum explaining your contentions as to your qualification under the program and the category (Tier II – level A or B) under which you have submitted your claim. (see Section 13 of the Term Sheet.) Pursuant to Section 13 of the Term Sheet, the memorandum is not to exceed five pages. Exhibits to the memorandum may be abstracts or full documents not to exceed thirty pages. No expert reports or affidavits shall be submitted.

I. With respect to all personal injury claims in which you are entitled to an award under this Program, before payment of such award shall be made, you must provide Lead Counsel for Defendant with the full names, relationship to the alleged personal injury Propulsid® user, dates of birth and Social Security numbers of all persons

entitled under applicable state law to make a claim (including but not limited to loss of consortium claims) or share in settlement proceeds resulting from the alleged Propulsid® user's ingestion of Propulsid®. Moreover, all such persons must comply with all provisions of the Term Sheet; and

J. You agree to obtain court approval of any settlement awarded under this Program, if such court approval is required under applicable state law; and

K. You agree to take all steps necessary for the court appointment of any persons required to represent minor or incompetent statutory heirs with respect to any claims submitted under this Program and any settlements awarded; and

L. If you are required to pursue any court proceedings with respect to finalizing any settlement under this Program, you agree that all such court proceedings must be maintained in the strictest confidence and that all court papers shall be filed under seal and all hearings held in private to the extent allowable under applicable state law and procedure. You also agree that drafts of all such court papers must be approved by Lead Counsel for Defendants before filing with the court and may in no event disclose the amount of any settlement award.

M. You also acknowledge that pursuant to Section 20 of the Term Sheet, upon submitting the requisite Claim Form, you must state whether or not you have reached a settlement with an entity other than the Janssen and Johnson & Johnson defendants. You also agree that if it is determined that you are eligible for an award payment, you must inform the Special Master exclusively of the amount of any such settlement.

N. By having enrolled in this Program, you acknowledged that the decisions of the Medical Panel and Special Master may be ones with which you disagree, but further acknowledge that this eventuality is part of the Program, and you accepted that eventuality by having authorized your attorney to enroll you in the Program. You further specifically agree that the decisions of the Medical Panel and Special Master are final and not appealable.

O. It is acknowledged that, having enrolled in this Program, you thereby surrendered your rights to litigate your case and any other claims and potential claims relating in any way to Propulsid®, including but not limited to all claims, liabilities, demands, actions, suits and causes of actions for damages (including but not limited to current and future causes of action for wrongful death, and current and future causes of action for personal injury and loss of consortium), restitution, disgorgement, unjust enrichment, civil penalties, statutory penalties, injunctive and/or declaratory relief, whether class, individual, representative or otherwise in nature, including costs, expenses, penalties, and attorneys' fees, known or unknown, suspected or unsuspected, in law or equity, that accrued prior to the date of enrolling in the Program that you ever had, now have or hereafter can, shall or may have, which has been asserted or could have been asserted in the MDL or in any other action and you acknowledge that having enrolled in

the Program, you unconditionally, fully and forever released whatever rights you, your heirs, beneficiaries and representatives may have had, or may ever have against defendants Johnson & Johnson, Janssen Pharmaceutica Inc. and Janssen Pharmaceutica, N.V., all health care professionals, health care providers, health care facilities, pharmacies and other distributors of Propulsid®, and their parents and subsidiaries, affiliates, agents, attorneys, servants, employees, officers and directors and those who may have acted in concert with them, together with their respective insurers, relating to your alleged ingestion of Propulsid®. You also acknowledge that when you enrolled in the Program, you were authorized to release the aforementioned claims on behalf of yourself and your heirs, beneficiaries and representatives and that you also waived California Civil Code Section 1542, if applicable, which provides that, "a general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor." You also acknowledge that if the Medical Panel determines that you are entitled to an award under this Program, you must comply with all of the provisions of the Term Sheet prior to payment of such award, including but not limited to preparing any documentation called for under the Term Sheet for finalizing payment.

Attorneys for Claimants and/or Plaintiffs shall provide a completed W-9 Form, a copy of which is attached hereto as Attachment D, which form shall provide, among other things, the appropriate tax identification number for that attorney.

P. The signatories to the Claim Form, the law firms with which they are affiliated and the Plaintiffs and Claimants identified on Attachment A specifically agree to maintain the confidentiality of any awards of compensation that might result from this Program.

Q. You agree to execute and serve with this Claim Form the original Authorization to Release Medical Records attached hereto as Attachment C.

III.
CLAIM FORM FOR PERSONAL INJURY (Tiers II and III)

A. ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, AS NECESSARY, ATTACH ADDITIONAL SHEETS:

1. Information re: Alleged Propulsid® User:

a. Current name and other names (e.g., maiden names, married names) used by the alleged Propulsid® user for the ten years prior to the alleged Propulsid® user's alleged adverse event through 60 days prior to service of this Claim Form (last name first, followed by first name and middle initial):

_____

b. Alleged Propulsid® User's Current Residence Address:

_____

_____

_____

c. Alleged Propulsid® User's DOB: _____

e. Alleged Propulsid® User's SSN: _____

2. Information for all Plaintiffs/Claimants Submitting this Claim re: the above-listed alleged Propulsid® user <u>if other than the alleged Propulsid® user</u> [attach separate sheet(s) as necessary to answer all of the following questions re: each such Plaintiff/Claimant]:

a. Current name and other names used by each Plaintiff/Claimant <u>at the time of and subsequent to</u> Plaintiff's filing of a Propulsid® lawsuit re: the alleged Propulsid® user's alleged ingestion of Propulsid® <u>or at the time of or subsequent to Claimant entering into a Tolling Agreement or joining the Achord action</u> with respect to the alleged Propulsid® user's alleged ingestion of Propulsid® (last name first, followed by first name and middle initial):

_____

b. Plaintiff's/Claimant's Current Residence Address:

_____

_____

_____

c. DOB: _____

d. SSN: _____

e. Relationship to Alleged Propulsid®User: _____

f. Details re: Plaintiff's/Claimant's relationship to alleged Propulsid® user (e.g., whether Plaintiff/Claimant is the representative of an alleged Propulsid® user who was/is a minor, etc.): _____. If Plaintiff/Claimant is a court-appointed representative, please attach copies of the court orders making such appointment.

3. Alleged Propulsid® User's Alleged Ingestion of Propulsid®:

a. Date(s) ingested: _____

b. Dosage(s) ingested (amount (e.g., 20mg.) and number daily):
_____/_____

c. Ordering Physician(s) Name(s), Addresses and Phone Numbers:

_____

d. Pharmacies where all Propulsid® Prescriptions were ever filled (names, addresses and phone numbers of all such pharmacies):

_____
_____
_____

4. Other Medications Used by Alleged Propulsid® User:

a. For each prescription medication ingested by the alleged Propulsid® user during the three years prior to the alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

b. For each over-the-counter medication ("OTC") ingested by decedent during the three months prior to the adverse event leading to decedent's death (or during decedent's entire life if decedent was under age 12 at time of death), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

5. Alleged Adverse Event:

a. Date of Alleged Adverse Event:

_____

b. Description of Nature of Alleged Adverse Event:

_____

c. Names, Addresses, Telephone Numbers of Physician(s), Physician's Assistants and Nurse Practitioners who treated the alleged Propulsid® user for the alleged injuries or adverse event he or she suffered that are being attributed to the alleged ingestion of Propulsid® and the dates of such treatment from the date of the alleged adverse event through 60 days before service of this Claim Form. (Include names, addresses and phone numbers of any pertinent treatment facilities, including but not limited to hospitals, ambulance or paramedic companies and fire department rescue crews.)

_____

_____

_____

6. Medical Treatment History:

a. For all medical treatment, of any kind, received by the alleged user in the one year prior to the alleged adverse event through 60 days before service of this Claim Form (or if the alleged Propulsid® user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) from any type of medical practitioner (doctors, physician's assistants, nurse practitioners, therapists, hospitals, clinics, pharmacies, ambulance services, paramedic companies and home health services) provide for each:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

b. For each of the alleged Propulsid® user's emergency room visits and hospitalizations during the three years preceding the alleged adverse event through 60 days before service of this Claim Form (or if the alleged Propulsid® user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days prior to submission of this Claim Form), provide the following:

(i) facility name;

(ii) facility address;

(iii) condition leading to hospitalization;

(iv) dates of admission; and

(v) duration of hospitalization.

c. For all of the following cardiac studies ***excluding*** **ECGs** (see 6.e. below re ECGs) performed during the three years before the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) ***including*** holter monitoring, stress tests, heart scans, echo-cardiograms, cardiac angiography/catheterization, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

d. For the three years prior to the alleged Propulsid® user's alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) for all treatment received by the alleged user from the alleged user's primary care physician(s), cardiologist(s), gastroenterologist(s) and/or pediatrician(s), provide:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

e. For the ten years prior to the alleged Propulsid® user's alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) for each **ECG**, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

f. For the ten years prior to the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide the following for all hospital records where cardiac concerns were implicated. Cardiac concerns include but are not limited to chest pain or angina, syncope (fainting or near fainting), heart attack, congestive heart failure, hypertension, cardiomyopathy, valvular disease, infections of the heart or heart valve and myocarditis.

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

g. For the ten years prior to the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide the following for all hospital records where GI concerns were implicated:

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

h. For each insurance or other company that provided medical bill coverage for the alleged Propulsid® user's health care for treatment of the alleged Propulsid-related adverse event and injuries allegedly resulting from said alleged adverse event from the date of the alleged adverse event through 60 days before service of this Claim Form, provide:

(i) company name of insurer;

(ii) address and telephone number; and

(iii) dates of coverage.

i. If any of the alleged Propulsid® user's medical expenses relating to his/her alleged ingestion of Propulsid® were covered by Medicare, Medicaid or military

benefits, i.e., V.A. or Tri-Star, so state, and describe any medical liens of which you are aware:

_____

7. **Economic Losses:**

List all economic losses you are claiming, including but not limited to lost wages, and in the event you are claiming economic loss in the form of lost wages, provide the name and address of the alleged Propulsid® user's employer, the alleged user's title at his or her place of employment and the dates of employment you claim were lost due to Propulsid® use:

_____

_____

_____

8. Propulsid®-Related Settlements With Other Third Parties:

a. State whether you have reached a settlement with any other party besides one of the Janssen or Johnson & Johnson defendants, e.g., including but not limited to with a doctor, hospital, pharmacy, or insurer:

_____

b. If you answered "yes" to question III.8.a. above, identify the name of the person and/or entity with whom the settlement was reached:

9. Pendency of Propulsid® Lawsuits and/or Claims:

a. State whether you are involved in any pending Propulsid®-related lawsuit or claim other than the one for which you are submitting this Personal Injury Claim Form:

_____

b. If you answered "yes" to question III.9.a. above, describe the name of, venue of, docket number (if a filed lawsuit) and parties to the lawsuit(s) and/or claim(s):

_____

_____

_____

B. COMPLETE, SIGN AND DATE CERTIFICATE OF SERVICE OF CLAIM FORM FOR PERSONAL INJURY (TIER II or TIER III) CLAIM IN THE FORM CONTAINED IN THE TEMPLATE CERTIFICATE OF SERVICE IN ATTACHMENT B.

C. SIGN AND DATE BELOW.

Dated: _____ [Plaintiff's/Claimant's Signature]
Printed Name of Plaintiff/Claimant
Printed Residence Address

Dated: _____ [Signature of Plaintiff's/Claimant's Attorney
Printed Individual Attorney Name
Law Firm Name, Address, Telephone/Fax

PROPULSID® MDL 1355 RESOLUTION PROGRAM
ATTACHMENT A TO ALL CLAIM FORMS
(Pursuant to Section 2. of Exhibit A to the Term Sheet)

2. MEDICAL RECORD REQUIREMENTS

A. **For a person who was age 12 or older at the time of the event.** The person's relevant medical records as defined in subpart D below, immediately preceding the date of the event must be provided to the Medical Panel.

B. **For a person who was under 12 at the time of the event.** The person's relevant medical records from birth through the date of the event must be provided to the Medical Panel

C. **For all people.** The person's relevant medical records from the time of the event until death, or until 60 days before the time the case is submitted under The Program, whichever is applicable. These records are of particular importance in the evaluation process.

D. **Relevant records.** For the purpose of this Program,. The following are a person's relevant medical records. Time periods are deemed appropriately modified where the person was less than twelve years of age at the time of the event. The PSC and J&J may agree to order supplemental records at the expense of the administrative expense fund.

(1) **The one-year period before the event.** Full records for any kind of medical care in the one year preceding the event (doctor, hospital, pharmacy, ambulance, therapy, etc.).

(2) **The three year period before the event.**

(a) Full hospital records for hospitalizations.

(b) All electrocardiogram, holter monitor, and other cardiac monitoring or testing records for the three years before the event.

(c) Physician records from the person's primary care physician or physicians (if any), cardiologist or cardiologists (if any), gastroenterologists and/or pediatrician or pediatricians (if any).

(d) Prescription records for all prescribed medications.

(3) **The ten-year period before the event.**

(a) Full hospital records where cardiac concerns are implicated.

(b) Full hospital records where GI concerns are implicated.

(c) Full EKG's.

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ATTACHMENT B TO CLAIM FORM FOR PERSONAL INJURY CLAIM

CERTIFICATE OF SERVICE OF CLAIM FORM FOR PERSONAL INJURY (TIER II OR TIER III) CLAIM

I, [INSERT name of signatory], declare that:

I am at least 18 years of age, and not a party to the above-entitled action. My business address is _____, Telephone: _____.

On_____, I caused to be served the following document(s):

CLAIM FORM(S) FOR PERSONAL INJURY (TIER II OR TIER III) CLAIM(S) OF [INSERT NAME OF PLAINTIFF/CLAIMANT OR IF SERVING MORE THAN ONE PERSONAL INJURY CLAIM FORM WITH THIS CERTIFICATE, INSERT NAMES OF ALL PLAINTIFFS/CLAIMANTS WHOSE FORMS ARE BEING SERVED WITH THIS CERTIFICATE

by enclosing a true copy of (each of) said document(s) in (an) envelope(s), addressed as follows:

☐ BY MAIL: I am readily familiar with the business' practice for collection and processing of correspondence for mailing with the United States Postal Service. I know that the correspondence is deposed with the United States Postal Service on the same day this declaration was executed in the ordinary course of business. I know that the envelope was sealed, and with postage thereon fully prepaid, placed for collection and mailing on this date, following ordinary business practices, in the United States mail at **[City and State.]**.

☐ BY PERSONAL SERVICE: I caused such envelopes to be delivered by a messenger service by hand to the address(es) listed below:

☐ BY OVERNIGHT DELIVERY: I enclosed a true copy of said document(s) in a Federal Express envelope, addressed as follows:

☐

Russ M. Herman, T.A.
HERMAN, MATHIS, CASEY,
KITCHENS & GEREL, LLP
820 O'Keefe Avenue
New Orleans, LA 70113
Telephone: (504) 581-4892
Facsimile: (504) 561-6024

Thomas F. Campion, Esq. **AND**
Charles F. Preuss, Esq.
DRINKER BIDDLE & REATH LLP
50 Fremont Street, 20th Fl.
San Francisco, CA 94105
Telephone: (415) 591-7500
Facsimile: (415) 591-7510

I declare under penalty of perjury under the laws of the State of [insert State of service] that the above is true and correct.

///

Executed on [Date] at [City and State].

[Name]

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PROPULSID® MDL 1355 RESOLUTION PROGRAM
ATTACHMENT C TO ALL CLAIM FORMS

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name or specific identification of the person(s), or class of persons, authorized to make the requested disclosure (Provider List):

TO: _____

_____

_____

Patient Name: _____

AKA's: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____ including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

I authorize you to release the protected health information to:
RecordTrak, 651 Allendale Road, PO Box 61591 King of Prussia, Pennsylvania 19406.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.
I acknowledge the right to revoke this authorization by writing to the ROA Agent at Recordtrak at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires one year from the date below.

Signature: _____ Date: _____
Relationship to the person who is the subject of the records:

Self: _____ Other: _____
Describe authority

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PROPULSID® MDL 1355 RESOLUTION PROGRAM
ATTACHMENT D TO ALL CLAIM FORMS

Form W-9 **Taxpayer Identification Number Request** Rev. March 2003

To: _____ Account Number: _____

Please complete the following information. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 30% federal income tax backup withholding (28% after December 31, 2003). Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 30% of its payment to you (28% after December 31, 2003). Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Use this form only if you are a U.S. person (including U.S. resident alien). If you are a foreign person, use the appropriate Form W-8.

Instructions:
1. *Complete Part 1 by completing the one row of boxes that corresponds to your tax status.*
2. *Complete Part 2 if you are exempt from Form 1099 reporting.*
3. *Complete Part 3 to sign and date the form.*
4. *Return this completed form to us in the enclosed envelope.*

Part 1 – Tax Status: *(complete only one row of boxes)*

Individuals: *(Fill out this row.)*	Individual Name: (First name, middle initial, last name)	Individual's Social Security Number
Sole Proprietor: *(Fill out this row.)*	A sole proprietorship may have a "doing business as" trade name, but the legal name is the name of the business owner. Business Owner's Name: (REQUIRED) (First Name) (Middle Initial) (Last Name)	Business Owner's Social Security Number or Employer ID Number / Business or Trade Name (OPTIONAL)
Partnership: *(Fill out this row.)*	Name of Partnership:	Partnership's Employer Identification Number / Partnership's Name on IRS records *(see IRS mailing label)*
Corporation, exempt charity, or other entity: *(Fill out this row.)*	A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation. Name of Corporation or Entity:	Employer Identification Number

Part 2 – Exemption: If exempt from Form 1099 reporting, check your qualifying exemption reason below:

- ☐ **Corporation** Note that there is no corporate exemption for medical and healthcare payments or payments for legal services.
- ☐ **Tax Exempt Entity** under 501(a) (includes 501 (c)(3)), or IRA
- ☐ **The United States or** any of its agencies or instrumentalities
- ☐ **A state, the District of Columbia, a possession** of the United States, or any of their political subdivisions or agencies
- ☐ **A foreign government or** any of its political subdivisions or an international organization in which the United States participates under a treaty or Act of Congress

Part 3 – Certification:

I certify under penalty of perjury that the Tax Identification Number I have provided is correct:

Person completing this form: _____
Signature: _____ Date: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ ZIP: _____

Please return this form in the enclosed envelope. Thank you for your cooperation.