

**CLAIM FORM**

**DOW CORNING / BRITISH COLUMBIA AND OTHER PROVINCES  
BREAST IMPLANT LITIGATION SETTLEMENT**

You must complete all pages of this form. Attach additional pages if space is insufficient.  
Please type or print legibly in ink.

**THE INFORMATION PROVIDED IN THIS FORM WILL REMAIN CONFIDENTIAL  
EXCEPT AS PROVIDED IN THE DOW CORNING / BRITISH COLUMBIA AND OTHER PROVINCES BREAST  
IMPLANT LITIGATION SETTLEMENT.**

**Please mail this form to:** Claims Administrator  
Dow Corning / British Columbia and Other Provinces Breast Implant Litigation Settlement  
c/o Deloitte & Touche LLP, P.O. Box 48660, Vancouver, B.C. Canada V7X 1A3

**To preserve eligibility for benefits under the Agreement:**

- You must submit a completed and signed Claim Form to the Claims Administrator postmarked on or before December 1, 2004 (the Initial Claim Deadline);
- You must submit Products Identification Documents to the Claims Administrator postmarked on or before December 1, 2004 (the Initial Claim Deadline);
- If you are asserting a Current Claim you must also submit Supporting Medical Documentation to the Claim Administrator postmarked on or before December 1, 2004 (the Initial Claim Deadline).

Refer to Exhibit D of the Settlement Agreement, Sections 2 and 4, for instructions regarding Product Identification Documentation and Supporting Medical Documentation.

If you fail to meet these deadlines, you will be barred completely and forever from receiving compensation pursuant to the Agreement.

**IDENTIFICATION OF CLAIMANT/SETTLEMENT CLASS MEMBER**

<b>BC Registration Number:</b>	<b>Deloitte File Number:</b>	<b>Date of Birth:</b>		
		<b>Day</b>	<b>Month</b>	<b>Year</b>

**NAME of CLAIMANT:**

<b>Surname:</b>	<b>First Name:</b>	<b>Middle Name:</b>	<b>Any Other Last Names You Have Used:</b>
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**CURRENT ADDRESS:**

<b>Street address or PO Box:</b>		
<b>City:</b>	<b>Province or State:</b>	<b>Postal Code or Zip Code:</b>

<b>TELEPHONE NUMBER:</b>	<b>Area Code:</b>	<b>Number:</b>	<b>EMAIL ADDRESS:</b>
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<b>US Bankruptcy Proof of Claim Number(s), if Any:</b>	<b>Province/Territory/State from the address which you included in your US Bankruptcy Proof of Claim:</b>
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<b>YOUR ADDRESS on AUGUST 1, 1998</b>	<b>City:</b>	<b>Province/Territory/State:</b>
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**PROVINCE OR TERRITORY WHERE CLAIMANT FIRST RECEIVED DOW CORNING BREAST IMPLANTS  
OR BREAST IMPLANTS CONTAINING DOW CORNING BREAST IMPLANT RAW MATERIALS**

<b>City:</b>	<b>Province/Territory/State:</b>
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**IDENTIFICATION OF CLAIMANT/SETTLEMENT CLASS MEMBER:**

<b>BC Registration Number:</b>	<b>Surname:</b>	<b>First Name:</b>
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**LEGAL REPRESENTATIVE INFORMATION**

<b>Surname:</b>		<b>First Name:</b>			
<b>Firm Name:</b>					
<b>Legal Representative's Address</b>		<b>Street address or PO Box:</b>			
<b>City:</b>		<b>Province/Territory/State:</b>		<b>Postal/Zip Code:</b>	
<b>Telephone Number:</b>	<b>Area Code:</b>	<b>Number:</b>	<b>Fax Number:</b>	<b>Area Code:</b>	<b>Number:</b>
<b>Email address:</b>					

**CLAIMS OPTIONS**

**YOU MUST CHOOSE ONLY ONE OF THE FOUR OPTIONS LISTED HERE TO RECEIVE BENEFITS.**

<input type="checkbox"/>	<b>1. Expedited Settlement Claim:</b> I elect to make a claim for an Expedited Settlement Claim payment of \$US 1,200. I understand that by choosing this option I exclude myself from ever receiving another payment from Dow Corning regarding Breast Implants or Breast Implant Raw Materials. With this Claim Form, I attach Product Identification Documentation to prove that I have or had Dow Corning Breast Implants.
<input type="checkbox"/>	<b>2. Raw Materials Claim:</b> I elect to make a Raw Materials Claim for payment of \$US 330. With this Claim Form, I attach Product Identification Documentation to prove that I have or had Breast Implants manufactured by a company other than Dow Corning that contains or contained Dow Corning Breast Implant Raw Material.
<input type="checkbox"/>	<b>3. Current Claim:</b> I elect to make a claim for compensation for the Designated Medical Condition checked below. With this Claim Form, I attach Product Identification Documentation to prove that I have or had Dow Corning Breast Implant(s), and Supporting Medical Documentation to prove that I suffer from the Designated Medical Condition checked below.
<b>Option I</b>	<b>Level A</b>
	<b>Level B</b>
	<b>Levels C &amp; D</b>
<b>Option II</b>	<b>Scleroderma/Lupus – Level A</b>
	<b>Scleroderma/Lupus – Level B</b>
	<b>Scleroderma/Lupus – Level C</b>
	<b>General Connective Tissue Syndrome/Polymyositis/Dermatomyositis – Level A</b>
	<b>General Connective Tissue Syndrome – Level B</b>
<b>Rupture</b>	<b>I elect to make a Rupture Claim. I understand that my Rupture Claim may be made alone or in addition to an election under Options I or II above.</b>
	With this Claim Form, I attach Product Identification Documentation and Rupture Documentation to prove that I had a Rupture of one or more Dow Corning Breast Implants. (Ongoing Claimants may make a Rupture Claim now and still preserve their right to make a claim under Option I or II prior to the Final Claim Deadline.)
<input type="checkbox"/>	<b>4. Ongoing Claim:</b> I elect not to make an Option I or Option II claim for compensation for a Designated Medical Condition at this time, but I wish to preserve my right to make such a claim prior to the Final Claim Deadline (June 1, 2009). With this Claim Form, I attach Product Identification Documentation to prove that I have or had Dow Corning Breast Implants.

**IDENTIFICATION OF CLAIMANT/SETTLEMENT CLASS MEMBER:**

BC Registration Number:

Surname:

First Name:

**AUTHORIZATION OF RELEASE OF MEDICAL RECORDS****If you are making a Current Claim or an Ongoing Claim, you must complete this authorization.**

I hereby authorize and direct the release to the Claims Administrator of any medical information or records held by any person concerning (1) the identity or identities of the manufacturer or manufacturers of any and all breast implants I have had, (2) any and all breast implant surgery or surgeries I have had, (3) any and all injuries, illnesses and other medical problems allegedly related to any and all breast implants I have had, and (4) any and all injuries, illnesses and other medical problems that predated any breast implantation I have had. For such release, this "Authorization of Release of Medical Records" shall be good and sufficient authority.

Signature of Witness:

Signature of Settlement Class Member (or Representative):

Name of Witness (type or print):

Date Signed:

 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Day      Month      Year

**I declare under penalty of perjury that the information on this Claim Form is true, correct and complete to the best of my knowledge, information and belief.**

Date Signed:

 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Day      Month      Year

Signature:

If signed by a Personal Representative, complete the Representative information below, and attach a copy of the court order or other document appointing you as the claimant's representative.

**REPRESENTATIVE INFORMATION if applicable:**

Surname:

First Name:

Middle Name:

Street address or PO Box:

City:

Province/Territory/State:

Postal/Zip Code:

Telephone Number:

Area Code:

Number:

Email address:

**NOTES:**

This claim form and the other claim documents, and important information about the Dow Corning/BC and Other Provinces Breast Implant Litigation Settlement and the claims procedures are available online at <http://www.canadianbreastimplantsettlement.com>

You, your lawyer, and/or your physician may find it easier to complete these forms online.

You should consult the above website on a regular basis for up-to-date information about the claims process.

All future materials will be mailed to a claimant's representative or solicitor, if applicable, care of the addresses included in this claim form.