

## ONGOING 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 the following to the Claims Administrator postmarked on or before JUNE 1, 2009 (the Final Claims Deadline):**

- A completed and signed Ongoing Claim Form;
- Product Identification Documentation;
- Supporting Medical Documentation;
- An Affidavit of Unrepresented Settlement Class Member or Solicitor's Certificate of Legal Advice; and
- A Release of Dow Corning and the Released Parties.

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 this deadline, you will be barred completely and forever from receiving compensation pursuant to the Settlement 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 surnames you have used:</b>
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#### CURRENT ADDRESS

**Street address or PO Box:**

<b>City:</b>	<b>Province or State:</b>	<b>Postal Code or Zip Code:</b>
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<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**

**Ongoing Claim:** I elect to make a claim for compensation for the Designated Medical Condition checked below. With this Ongoing 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>

**AUTHORIZATION OF RELEASE OF MEDICAL RECORDS**

**If you are making 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.

<b>Signature of Witness:</b>	<b>Signature of Settlement Class Member (or Representative):</b>
<b>Name of Witness (type or print):</b>	<b>Date Signed:</b> ____/____/____ <b>Day Month Year</b>

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

<b>BC Registration Number:</b>	<b>Surname:</b>	<b>First Name:</b>
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**DECLARATION – If you are making an Ongoing Claim you must sign this declaration.**

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

<b>Date Signed:</b>  ____/____/____ <b>Day      Month      Year</b>	<b><u>Signature of Settlement Class Member (or Representative):</u></b>  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.
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**REPRESENTATIVE INFORMATION (if applicable)**

<b>Surname:</b>	<b>First Name:</b>	<b>Middle Name:</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>Email address:</b>

<b><u>NOTES:</u></b>	All future materials will be mailed to a claimant’s representative or legal representative, if applicable, care of the addresses included in this Ongoing Claim Form.
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