

**A and I Corporation**  
**Claim and Lawsuit Data Upload File Format**

Claim Form			Data File									
Section	Label	Mapping Column Name	Required	Format	Max Length	Valid Values						
Claim Form	Type of Review	ReviewTypeID	Yes	Numeric	1	Use the integers from the table below: <table border="1"> <thead> <tr> <th>ReviewTypeID</th> <th>Review Type</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Expedited</td> </tr> <tr> <td>2</td> <td>Secondary Exposure</td> </tr> </tbody> </table>	ReviewTypeID	Review Type	1	Expedited	2	Secondary Exposure
ReviewTypeID	Review Type											
1	Expedited											
2	Secondary Exposure											
Claim Form	Firm's Matter Number	MatterNbr	Yes	Alphanumeric	100	This will be the reference number that will be used to link all the claim data across multiple data files.						
Injured Party Information	Last Name	LastName	Yes	Text	50							
Injured Party Information	First Name	FirstName	Yes	Text	50							
Injured Party Information	Middle Name	MI	No	Text	50							
Injured Party Information	Suffix	Suffix	No	Text	50							
Injured Party Information	Social Security Number	SSN	Yes	Text ###-##-#### #####	50	If a US SSN, must be in the format: ###-##-#### or #####						
Injured Party Information	Date of Birth	DOB	Yes	Varying	Format Specific							
Injured Party Information	Gender	Gender	Yes	Text	6	"Male" or "Female" or "M" or "F" (Case insensitive)						
Injured Party Information	Date of Death	DOD	No	Varying	Format Specific							
Injured Party Information	Was death asbestos Related?	AsbestosRelatedDeath	Yes <sup>1</sup>	Alphanumeric	3	Yes, No, Y, N, 1 (Yes) or 0 (No) Required if Injured Party is deceased						
Injured Party Information	Mailing Address	Addr1	No	Text	100							
Injured Party Information	Mailing Address	Addr2	No	Text	100							
Injured Party Information	City	City	No	Text	50							
Injured Party Information	State	State	No	Text	10	For US address you must provide a valid 2 character postal state code. For a Non-US address, the State/Province will not be validated.						
Injured Party Information	Zip Code	Zip	No	Text ##### #####-####	50	For US address the ZIP Code must be in one of the allowed formats. For a Non-US address, the ZIP/Postal Code will not be validated.						
Injured Party Information	Country	Country	No	Text	100	Country.CountryName						
Injured Party Information	Daytime Telephone	DayPhone	No	Text	50	Free form text. If a US State apply US phone Number validation: <table border="1"> <tbody> <tr> <td>###-####</td> <td>EX: 555-5555</td> </tr> <tr> <td>###-###-####</td> <td>EX: 732-555-5555</td> </tr> <tr> <td>#-###-###-####</td> <td>EX: 1-732-555-5555</td> </tr> </tbody> </table> Only Numbers allowed	###-####	EX: 555-5555	###-###-####	EX: 732-555-5555	#-###-###-####	EX: 1-732-555-5555
###-####	EX: 555-5555											
###-###-####	EX: 732-555-5555											
#-###-###-####	EX: 1-732-555-5555											
Injured Party Information	Email Address	Email	No	Text	50	Must contain "@" and "."						
Law Firm/Attorney Information	Filer ID	AttorneyID	Yes	Numeric	5	Filer ID provided by Verus upon registration						

**A and I Corporation**  
**Claim and Lawsuit Data Upload File Format**

Claim Form			Data File			
Section	Label	Mapping Column Name	Required	Format	Max Length	Valid Values
Asbestos Related Injury	Disease Level	DiseaseLevelID	Yes	Numeric	1	Use the integers from the table below: <b>DiseaseLevelID    Disease Level</b> 1                    Level V 2                    Level IV 3                    Level III 4                    Level II 5                    Level I
Asbestos Related Injury	Diagnosis Date	DiagnosisDate	Yes	Varying	Format Specific	Must be after DOB
Asbestos Related Injury	If Other Cancer (Level V) please specify malignancy	OtherCancerMalignancy	No	Text	50	Required if claim is filed with a disease Level of "V" (Other Cancer). If Disease Level is not 5 leave this field blank
Asbestos Litigation and Claims History	File Date	FileDate	Yes <sup>2</sup>	Varying	Format Specific	If no lawsuit filed leave blank
Asbestos Litigation and Claims History	State	FileState	Yes <sup>2</sup>	Text	2	Two letter abbreviation for state; if no lawsuit filed, <i>leave blank</i>
Asbestos Litigation and Claims History	Court	FileCourt	Yes <sup>2</sup>	Text	100	If no lawsuit filed, leave blank
Asbestos Litigation and Claims History	Docket Number	Docket	Yes <sup>2</sup>	Text	50	If no lawsuit filed, leave blank
Asbestos Litigation and Claims History	A&I Named	AINamed	No	Alphanumeric	3	Yes, No, Y, N, 1 (Yes) or 0 (No)
Asbestos Litigation and Claims History	Previously Settled	PreviousSettleFlag	Yes <sup>3</sup>	Alphanumeric	3	Yes, No, Y, N, 1 (Yes) or 0 (No)
Asbestos Litigation and Claims History	Amount of Prior Settlement	PriorSettlementAmount	Yes <sup>3</sup>	decimal	10,2	> 0
Asbestos Litigation and Claims History	Unfiled Jurisdiction Selection	UnfiledState	Yes <sup>4</sup>	Text	2	Valid 2 character US Postal State Code
Secondary Exposure	Date Exp. to Other Person Began	SecondExpStartDate	Yes <sup>5</sup>	Varying	Format Specific	
Secondary Exposure	Date Exp to Other Person Ended	SecondExpEndDate	Yes <sup>5</sup>	Varying	Format Specific	
Secondary Exposure	Relationship to Occupationally Exposed Person	SecondRelationship	Yes <sup>5</sup>	Text	50	
Secondary Exposure	SSN of Occupationally Exposed Person	SecondSSN	Yes <sup>5</sup>	Text ###-##-#### #####	50	If a US SSN, must be in the format: ###-##-#### or #####
Secondary Exposure	Description of how the Injured Party was exposed through Occupationally Exposed Person	SecondDesc	Yes <sup>5</sup>	Text	1000	

- Notes:**
- <sup>1</sup> Required if Injured Party is deceased DateOfDeath has a value)
  - <sup>2</sup> If at least one field of the Asbestos Litigation section is populated, the File Date, State, and Court must also be populated; if no lawsuits were filed, enter the state selected for the venue in the "Unfiled Jurisdiction Selection"
  - <sup>3</sup> Required if Previously Settled is "Yes"
  - <sup>4</sup> Required if no lawsuits were filed. Enter the state based upon state of residence or where exposure occurred.
  - <sup>5</sup> Required if ReviewTypeID = 4 (Secondary Exposure)

**A and I Corporation  
Personal Representative  
Data Upload File Format**

Claim Form			Data File				
	<u>Section</u>	<u>Label</u>	<u>Mapping Name</u>	<u>Required<sup>1</sup></u>	<u>Format</u>	<u>Max Length</u>	<u>Valid Values</u>
		Matter Number	MatterNbr	Yes <sup>1</sup>	Alphanumeric	100	Your reference Number - Links the data in this file back to the claim it belongs to.
	Personal Representative	Last Name	LastName	Yes <sup>1</sup>	Text	50	
	Personal Representative	First Name	FirstName	Yes <sup>1</sup>	Text	50	
	Personal Representative	Middle Name	MI	No	Text	50	
	Personal Representative	Suffix	Suffix	No	Text	50	
	Personal Representative	Foreign Tax ID Flag	ForeignTaxIDFlag	No	Alphanumeric	3	Yes, No, Y, N, 1 (Yes) or 0 (No)
	Personal Representative	Social Security Number	SSN	No	Text ###-##-#### #####	50	If a US SSN, must be in the format: ###-##-#### or #####
	Personal Representative	Capacity of Personal Rep	Capacity	Yes <sup>1</sup>	Text	50	
	Personal Representative	Mailing Address	Addr1	No	Text	200	
	Personal Representative	Mailing Address	Addr2	No	Text	200	
	Personal Representative	City	City	No	Text	50	
	Personal Representative	State	State	No	Text	2	For US address you must provide a valid 2 character postal state code. For a Non-US address, the State/Province will not be validated.
	Personal Representative	Zip Code	Zip	No	Text ##### #####-####	50	For US address the ZIP Code must be in one of the allowed formats. For a Non-US address, the ZIP/Postal Code will not be validated.
	Personal Representative	Country	Country	No	Text	100	
	Personal Representative	Daytime Telephone	DayPhone	No	Text	50	Free form text. If a US State apply US phone Number validation: ###-#### EX: 555-5555 ###-###-#### EX: 732-555-5555 #-###-###-#### EX: 1-732-555-5555 Only Numbers allowed

**Notes:**

<sup>1</sup> If you provide Personal Representative data for the injured party, then the fields marked as "Yes" are required.

**A and I Corporation  
Exposure History  
Data Upload File Format**

Claim Form			Data File				
	<u>Section</u>	<u>Label</u>	<u>Mapping Name</u>	<u>Required</u> <sup>1</sup>	<u>Format</u>	<u>Max Length</u>	<u>Valid Values</u>
		Matter Number	MatterNbr	Yes <sup>1</sup>	Alphanumeric	100	Your reference Number - Links the data in this file back to the claim it belongs to.
	Occupational Exposure t	Start Date	StartDate	Yes <sup>1</sup>	Varying	Format Specific	
	Occupational Exposure t	End Date	EndDate	Yes <sup>1</sup>	Varying	Format Specific	> JobsiteStartDate
	Occupational Exposure t	Occupation	Occupation	Yes <sup>1</sup>	Text	50	
	Occupational Exposure t	Approved Site Code	ApprovedSiteCode	Yes <sup>2</sup>	Alphanumeric	50	Use code in the attached Approved JobSite Listing
	Occupational Exposure t	Site of Exposure (i.e. Plant or Site Name)	JobSite	Yes <sup>2</sup>	Text	50	
	Occupational Exposure t	City	City	Yes <sup>2</sup>	Text	100	
	Occupational Exposure t	State	State	Yes <sup>2</sup>	Text	2	For US address you must provide a valid 2 character postal state code. For a Non-US address, the State/Province will not be validated.
	Occupational Exposure t	Country	Country	Yes <sup>2</sup>	Text	100	
	Occupational Exposure t	Name of all Kasier Aluminum & Chemical Products to which claimant was exposed	Product	No	Text	1000	
	Occupational Exposure t	Describe the circumstances of asbestos exposure	ExpDesc	No	Text	1000	

**Notes:**

<sup>1</sup> At least ONE Exposure record is required in order for a claim to be accepted. For each Exposure record provided the fields marked as "Yes" are required.

<sup>2</sup> If the Approved Site Code is provided, you do not need to provide the Job Site Location information.  
If the Approved Site Code is **not** provided you are required to provide the Job Site Location information.

<sup>3</sup> Must provide an Industry Description, if "Other Industry" is selected from the list of Industry Codes

**A and I Corporation  
Documents  
Data Upload File Format**

Claim Form			Data File				
	<u>Section</u>	<u>Label</u>	<u>Mapping Name</u>	<u>Required</u> <sup>1</sup>	<u>Format</u>	<u>Max Length</u>	<u>Valid Values</u>
		Matter Number	MatterNbr	Yes <sup>1</sup>	Text	100	Your reference Number - Links the data in this file back to the claim it belongs to.
	Checklist of Supporting Documentation	Supporting Documentation	DocTypeID <sup>2</sup>	Yes <sup>1</sup>	Numeric	2	Use the Document Type Reference Number from the attached list of valid document types.
	Checklist of Supporting Documentation	n/a	FileName	Yes <sup>1</sup>	Text	200	Valid File Name that should exist in the corresponding document upload

**Notes:**

<sup>1</sup> If you provide any document information for the injured party, then the fields marked as "Yes" are required.

<sup>2</sup> See table below for valid document types

<u>DocTypeID</u>	<u>Document Type</u>
1	Other
6	PFT Report
7	Pathology Report
8	Medical Report
12	Work History
14	Death Certificate
15	Estate Papers
16	Claim Form
18	All Supporting Documents
19	ILO Chart/CXR Reading
22	Release
25	Prior Asbestos Release
30	Exposure Affidavit/Sworn Statement