

Plibrico Asbestos Trust Claim Form

General Instructions for filing the Individualized Review Claim Form:

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; *submitting an incomplete form may result in delays in processing, and/or the Trust may not be able to assign the claim a position in the FIFO processing queue.* Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the Review election that best suits the injured party's situation:

Expedited Individualized Extraordinary Secondary Exposure

If electing Exigent treatment, check the box that applies: Exigent Hardship Exigent Health

Section 1: Injured Party Information			Firm's Matter # for this claim:	
Last Name	First Name	Middle Name	Suffix	
Social Security Number _____ - ____ - ____	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Death (mm/dd/yyyy)	Was asbestos a substantial factor or a proximate cause of claimant's death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if not represented by counsel)				
City	State	ZIP Code	Daytime Telephone	

Section 2: Law Firm / Attorney Information

If the injured party is represented by counsel, please provide the following information:

Law Firm Name			Filer ID	
Mailing Address				
City			State	ZIP Code
Attorney Last Name	Attorney First Name	Attorney Middle Name		Suffix
Direct Telephone	Facsimile	Email Address		

Section 3: Asbestos Related Injury

Check the box next to the highest Disease Level the injured party is claiming.

Disease Level	
<input type="checkbox"/> Other Asbestos Disease (Level I) <input type="checkbox"/> Asbestosis/Pleural Disease (Level II) <input type="checkbox"/> Severe Asbestosis (Level III) <input type="checkbox"/> Other Cancer (Level IV) <input type="checkbox"/> Lung Cancer 2 (Level V) <input type="checkbox"/> Lung Cancer 1 (Level VI) <input type="checkbox"/> Mesothelioma (Level VII)	
Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level IV), please specify malignancy:

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Section 4: Smoking History (Not Required for Expedited Review or mesothelioma claims)

In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of packs smoked per day. Indicate fractional packs as decimals (e.g. enter 1/2 pack per day as 0.5)

Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day

Section 5: Personal Representative (if injured party is deceased or incompetent)

Last Name		First Name		Middle Name		Suffix	
Social Security Number ____-____-____		Capacity of Personal Representative (i.e. Administrator, Executor, Guardian, Spouse etc.)					
Mailing Address (If injured party is not represented by counsel)							
City			State	ZIP Code		Daytime Telephone	

Section 6: Asbestos Litigation

If an asbestos-related lawsuit has ever been filed on behalf of the injured party, provide the following information:

File Date (mm/dd/yyyy)	State	Court					
Docket Number						Plibrico Named? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has injured party received settlement monies related to this lawsuit from the Plibrico Entities or its insurers? <input type="checkbox"/> Yes <input type="checkbox"/> No				If "yes", Amount:			
If no lawsuit has ever been filed against the Plibrico Entities on behalf of the injured party, indicate in which state the claimant would have elected to file such suit:							State

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Section 7: Occupational Exposure to Asbestos Products

Provide the information below for each location at which claimant alleges exposure to asbestos occurred. Please include detail for all asbestos exposure which you think is sufficient to meet the Plibrico Exposure criteria as well as Significant Occupational Exposure criteria for the approval of the claim at the claimed Disease Level. List each site, industry and occupation combination separately. Provide the complete name and location of each individual site. *Attach additional copies of this page if more space is required.*

Exposure Site 1

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State Country
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Plibrico Products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

Exposure Site 2

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State Country
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Plibrico Products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

Exposure Site 3

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State Country
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Plibrico Products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

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Section 7 (cont'd): Occupational Exposure to Asbestos Products

Extraordinary Claims

If the claimant is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claimant satisfies Section 5.3(a) of the TDP:

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Section 8: Secondary Exposure (*Not Required for Expedited Review*)

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person, complete Section 7, Part 1 with the exposure information for the occupationally exposed person, and provide the information below:

Date Exposure to Other Person Began (mm/dd/yyyy)	Date Exposure to Other Person Ended (mm/dd/yyyy)	Relationship to Occupationally Exposed Person
Description of how injured party was exposed to Plibrico Products:		

Section 9: Employment / Earnings information (*Not Required for Expedited Review*)

If economic losses are being claimed, you must enclose an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Partially Disabled <input type="checkbox"/> Fully Disabled <input type="checkbox"/> N/A (Deceased)	
Amount of Last Annual Wages	Date of Last Wage Received (mm/dd/yyyy)

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Section 10: Dependents (Not Required for Expedited Review)

List the injured party's spouse, dependents, and any other individuals with right to a claim on behalf of the injured party.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent 5

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent 6

Last Name	First Name	Middle Name	Suffix
Relationship to Injured party	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Section 11: Certification and Signature

Certification of Asbestos Voting Claims

For claims (i) filed against the Plibrico Entities prior to March 13, 2002, and (ii) claims filed against another defendant in the tort system prior to the date the Plan was filed with the Bankruptcy Court,

- The claimant or his/her authorized agent was prevented from voting in the confirmation proceeding as a result of circumstances related to Hurricanes Katrina, Rita, Wilma or other events resulting in a state of emergency in the relevant jurisdiction that affected the claimant or his/her authorized agent.

This claim form must be signed by the claimant's attorney, or if not represented by an attorney, the claimant or his/her personal representative.

I have reviewed the information provided on this claim form, and all documents submitted in support of this claim. I hereby certify, under penalty of perjury, that this information is accurate and complete to the best of my knowledge, and that all available documentation has been provided as required by the Trust Distribution Procedures, including but not limited to all medical reports required by Sections 5.6(a)(1)(A), 5.6(a)(1)(B) and 5.6(a)(1)(C) therein.

Signed	Date Signed
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Print Name Here

To file by mail, send this completed form and all supporting documentation to:

Plibrico Asbestos Trust
c/o Verus Claims Services, LLC
57 Hamilton Avenue
Hopewell, NJ 08525

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Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form:

For all claimants:

- Medical records supporting the diagnosis of the claimed Disease Level (see Instructions for requirements)
- Proof of Plibrico Company or Plibrico Sales & Service, Inc. product exposure, as set forth in the detailed Filing Instructions

For deceased claimants:

- Death certificate
- Letters of Administration or other proof of personal representative's official capacity

For Exigent Hardship Claims and/or claimants asserting a claim for Lost Wages:

- Documentation supporting the claim that any and all wage loss incurred by the injured party was the direct result of injured party's asbestos-related disease. This documentation would include, but not be limited to medical records and/or reports, reports from governmental or insurance agencies and/or reports from claimant's most recent employer.
- Tax returns and/or W-2 forms for the last three (3) full years of employment.

For Exigent Health Claims Only:

- A declaration or an affidavit made under penalty of perjury by a physician who has examined the injured party within one hundred and twenty (120) days of the declaration or affidavit in which the physician states (a) that there is a substantial medical doubt that the injured party will survive beyond six (6) months from the date of the declaration or affidavit, and (b) that the injured party's terminal condition is caused by the relevant asbestos-related disease.