UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
SOUTH BEND DIVISION

IN RE: BIOMET M2a MAGNUM HIP IMPLANT PRODUCTS LIABILITY LITIGATION (MDL 2391)	)	CAUSE NO. 3:12-md-2391
This Document Relates to All Cases	)	

ORDER

Following discussion at the March 18, 2013 case management conference, the parties reached an agreement regarding the format and content of the Plaintiff Fact Sheet. A copy of that document is attached hereto, and is incorporated by reference as Exhibit D to the February 15, 2013 Case Management Order [Doc. No. 242].

SO ORDERED.

ENTERED: March 25, 2013

/s/ Robert L. Miller, Jr.
Judge, United States District Court
Northern District of Indiana

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
SOUTH BEND DIVISION

IN RE: BIOMET M²a MAGNUM HIP IMPLANT PRODUCTS LIABILITY LITIGATION (MDL 2391)	)	**CAUSE NO. 3:12-MD-2391-RLM-CAN** **Judge Robert L. Miller, Jr.**

PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. If the below information is not included in your medical records, or if you have additional information beyond your medical records, please fill in as appropriate. Otherwise, please make reference to the medical records for the information, including specific reference to the healthcare provider being referenced. If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the remaining questions with respect to the person who had the M²a Hip Implant System (the "M²a Device") implanted.

As used in this form, "Healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In filling out any section or sub-section of this form, please submit additional sheets as necessary to provide complete information. In addition, if you learn that any of your responses are incomplete or incorrect at any time, please supplement or amend your responses to provide that information as soon as you become aware of it. This form requests information and documents about your medical condition for a specified period of time. However, Defendants reserve the right to request additional information and information for a time period dating further back on a case by case basis, at which time the parties will meet and confer as the issue arises.

This Plaintiff Fact Sheet constitutes discovery responses subject to the Federal Rules of Civil Procedure. In completing this Plaintiff Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If the response to any question is that the person completing this Plaintiff Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney if you have any questions regarding the completion of this form.

I. CASE INFORMATION

1. Name of person completing this form:_____

2. Name of person on whose behalf a claim is being made:_____

3. Please state the following for the civil action that you filed pertaining to the M²a Device:

   a. Case caption:_____

   b. Case/Docket Number:_____

   c. Court in which action was originally filed:_____

   d. Contact information for the principal attorney representing you:

      Attorney Name:_____

      Firm:_____

      Address:_____

      Telephone Number:_____

      Fax Number:_____

      Email Address:_____

4. If you are completing this Plaintiff Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person), please complete the following:

   a. Your name, including other names you have used or by which you have been known and dates you used those names:_____

      _____

   b. Current Address:_____

   c. In what capacity are you representing the individual or estate: _____

   d. If you were appointed as a representative by a court, state the:

      Court that appointed you:_____

      Date of appointment:_____

   e. What is your relationship to the individual you represent:_____

   f. If you represent a decedent's estate, state the date of death:_____

The rest of this Plaintiff Fact Sheet requests information about the person who was implanted with the M²a Device. If you are completing this form in a representative capacity, please respond to the remaining questions with information about the person who was

implanted with the M²a Device. Whether you are completing this Plaintiff Fact Sheet for yourself or for someone else, "you" means the person who had the M²A Device implanted.

II. CORE INFORMATION

NOTE: IF YOU WERE IMPLANTED WITH MORE THAN ONE M²A DEVICE, COMPLETE THE QUESTIONS IN THIS SECTION FOR EACH IMPLANT SURGERY INVOLVING AN M²A DEVICE.

NOTE: IF THE BELOW INFORMATION IS INCLUDED IN YOUR MEDICAL RECORDS, YOU MAY MAKE REFERENCE TO THE MEDICAL RECORDS FOR THIS INFORMATION.

1. Type of M²a Device:_____

2. Side of body (please circle one): Right Left Both

3. Product Code/Lot Code for each component of the M²a Device (please attach a copy of the bar code stickers shown on the operative report):_____
_____
_____
_____

4. Dates of Implantation: _____

5. Name and Address of Implanting Surgeon(s):_____
_____

6. Name and Address of Hospital or Clinic where surgery(ies) were performed:_____
_____

7. If the M²a Device(s) has been removed, provide the date on which it was removed:_____
_____

8. If the M²a Device has been removed, to your knowledge has it been tested or inspected in any way? Yes:_____No:_____ If yes, please state:

   a. Date(s) it was tested: _____

   b. Name and address of person or entity that conducted testing:_____
   _____

   c. Results of testing:_____

9. Name and Address of Surgeon(s) who removed the M²a Device(s): _____
_____

10. Name and Address of Hospital or Clinic where surgery(ies) performed:_____
_____

11. Name of the Manufacturer and size of the replacement device, if any:_____
_____

12. Did you pay for your initial surgery and all related care?

Yes_____ No_____ In part_____

13. Were any of the components of the M²a Device surgically removed? Yes ____ No____

a. If Yes, what is the present location of the removed components of the M²a Device?_
_____

14. If you have not had any components of your M²a Device removed surgically, do you presently plan to have any of the components removed?

Yes_____ No_____ Undecided_____

If yes, please state:

a. Date scheduled for the surgery to remove/replace the M²a Device(s):_____
_____

b. Name and Address of Surgeon(s) who will perform the surgery:_____
_____

c. Name and Address of Hospital or Clinic where surgery will be performed: _____
_____

d. Reason for the surgery: _____
_____

15. Has any doctor ever told you that you need to have any components of your M²a Device removed? Yes_____ No_____

If yes, please provide name and address of each such doctor:_____
_____

16. Has any doctor told you that your medical condition prevents you from having any components of your M²a Device removed? Yes_____ No_____

If yes, please provide name and address of each such doctor:_____
_____

17. Have you received any other treatment or testing related to your M²a Device? Yes___No___
If yes, please state:

Date	Facility Name	Address and Telephone Number	Reason	Results

III. PERSONAL INFORMATION

1. Name (first, middle name or initial, last):_____

2. Maiden or other names used and dates you used those names:

3. Gender: Male:_____ Female:_____

4. Current address and date when you began living at this address:_____

_____

5. Identify each address at which you resided for the period from five years before your first hip surgery and up to the present and the dates you resided at each one.

Address	Dates of Residence

6. Social Security Number:_____

7. Date and place of birth:_____

8. Current marital status:_____

9. If married, please provide the following information:_____

   a. Date of marriage:_____

   b. Name of spouse:_____

   c. Date and place of birth of spouse:_____

10. If married, has your spouse filed a loss of consortium or other claim in this action?

    Yes_____ No_____

11. If you have children, list each child's name and date of birth.

_____

_____

12. Are you currently employed? Yes_____ No_____

If yes, please identify your current employer with name, address and telephone number and your position there:_____

_____

If not, did you leave your last job for a medical reason? Yes_____ No_____

If yes, describe why you left:

_____

_____

13. For the period of time from three years before you had your first hip surgery until the present, please identify all of your employers, with name, address and telephone number, your employment dates, your position there, and your reason for leaving:

Name of Employer	Address and Telephone Number	Dates of Employment	Describe Your Position or Duties and Specify if Job Required Manual Labor	Reason for Leaving

14. For the period from three years before your first hip surgery until the present, please indicate if you have actively participated in any sports: Yes_____ No _____

If yes, please state:

Type of Sport	Dates/Years played	Approximate # of hours you played per week	Approximate # of hours you practiced per week

15. For the period from three years before your first hip surgery until the present, please indicate if you have regularly exercised: Yes_____ No _____

If yes, please state:

Type of Exercise	Dates/Years Exercised	Approximate hours/week	Period of times during which you performed this exercise (month/year)	Location of Exercise (e.g. gym name/address)

16. Have you ever served in any branch of the military? Yes_____ No_____

a. Branch and dates of service:_____

b. If yes, were you ever discharged for any reason relating to your medical or physical condition?_____

_____

c. If yes, state what that condition was:_____

17. Have you ever been rejected from military service for any reason relating to your medical or physical condition? Yes_____ No_____

a. If yes, state what that condition was:_____

18. If you have Medicare, please state your HICN number:_____

19. For the period from three years before your first hip surgery to the present, have you been on or applied for workers' compensation, social security, and/or state or federal disability benefits? Yes_____ No_____

If yes, then as to each application, separately state the following and attach any documents you have which relate to the application and/or award of benefits:

a. Date (or year) of application:_____

b. Type of benefits:_____

c. Nature of claimed injury/disability: _____

d. Period of disability:_____

e. Amount awarded:_____

f. Basis of your claim:_____

g. Was your claim denied? Yes_____ No_____

h. To what agency or company did you submit your application:_____

i. Claim/docket number, if applicable:_____

20. Have you ever been involved in an accident or event, in which or as a result of which you suffered any personal injuries to your legs, hips or pelvic area? Yes_____ No_____

If yes, please provide the following information and attach copies of any accident reports:

Place and Date of Accident	Circumstances, Nature, Location, and Extent of Injury	Nature of Activity at Time of Injury	Names and Addresses of Treating Physician(s)

21. Have you ever been out of work for more than 30 consecutive days for any reasons related to your health in the last 10 years? Yes_____ No_____

If yes, please state:

Date(s) you were out of work:_____

Reason(s) you were out of work:_____

22. Have you ever filed a lawsuit or made a claim against a healthcare provider, pharmaceutical company, or medical device manufacturer? Yes_____ No_____

If yes, please attach copies of all pleadings, releases or settlement agreements and deposition transcripts you have, and provide the following information:

Party You Sued/Made Claim Against	Court in Which Suit Filed/Claim Made	Case/Claim Number	Attorney Who Represented You	Nature of Claim and Injury

23. Have you ever been convicted of, or pled guilty to, a felony and/or a crime of fraud or dishonesty within the past ten years? Yes_____ No_____

If yes, please state the charge to which you plead guilty or which you were convicted of, as well as the court where the action was pending:_____

_____

24. Have you or your spouse ever declared bankruptcy since the date of your original hip implantation surgery? Yes_____ No_____

If yes, please state when and in what court you filed your bankruptcy petition, including the docket number of the petition and the orders of discharge:_____

_____

25. Have you read or seen any written, televised, or internet-based advertising or labeling material related to the M²a Device or any other metal-on-metal hip prostheses?

Yes_____ No_____

If Yes, please state which advertising or material you read or saw, and approximately when.

_____

_____

_____

26. Since you received your M²a Device, have you posted a comment, message or blog entry on a public internet site (e.g. no password required for access) in which you have discussed or described your M²a Device experience, injury, disability, pain or physical complaints related to the M²a Device? (You should include non-password protected postings on public social network site including Twitter, Facebook, MySpace, Linked In, or "blogs" where the general public may post M²a Device related comments).

Yes_____ No_____

If yes, please state where and when you made such public posts and the substance of what was posted. Do not include posting that were provided exclusively to your attorney or his/her representative.

IV. HEALTHCARE PROVIDERS

NOTE: IF THE BELOW INFORMATION IS INCLUDED IN YOUR MEDICAL RECORDS, YOU MAY MAKE REFERENCE TO THE MEDICAL RECORDS FOR THE INFORMAITON.

1. Identify each doctor or healthcare provider (including but not limited to family/primary care physicians, orthopedic surgeons, physical therapists, chiropractors, practitioners of the healing arts) whom you have seen for medical care and treatment for the period five years before your first hip surgery to the present (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name and Specialty	Address and Telephone Number	Approx Dates/Years of Visits	Reason

2. Identify each hospital, clinic, surgery center, healthcare facility, physical therapy or rehabilitation centers where you have received medical treatment (in-patient, out-patient, or emergency room visit) for the period five years before your first hip surgery to the present (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name	Address	Admission Date(s)	Reason	Type of Surgery (if applicable)	Name of Surgeon (if applicable)

3. Identify each facility at which radiographs (x-rays, ultrasounds, MRIs, CT scans) were taken in the last 10 years of your hips, pelvis or legs.

Name	Address and Telephone Number	Approx Date Taken	Reason

4. Identify each laboratory at which your blood was tested in the last 10 years for blood levels of any metals, including cobalt and chromium.

. Name	Address and Telephone Number	Approx Date Taken	Reason	Results (if known by you)

5. Identify each pharmacy, drugstore or any other facility or supplier (including but not limited to mail order pharmacies) where you ever received any prescription medication for the period five years before your first hip surgery to the present (except for medicine for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

Name of Pharmacy/Supplier	Address and Telephone Number of Pharmacy/Supplier	Approx Dates/Years You Used Pharmacy/Supplier

V. MEDICAL BACKGROUND

NOTE: IF THE BELOW INFORMATION IS INCLUDED IN YOUR MEDICAL RECORDS, YOU MAY MAKE REFERENCE TO THE MEDICAL RECORDS FOR THE INFORMATION.

1. Current Height:_____

2. Please state your weight at the following times:

   a. Current:_____

   b. Time of implant:_____

   c. Time of revision surgery (if any):_____

3. Smoking History

   a. Have you ever smoked cigarettes? Yes _____ No_____

   State brand(s) smoked:_____

   State amount smoked:_____ packs per day for _____ years, during the years _____ to _____.

   b. Have you ever smoked cigars or pipe tobacco or used smokeless tobacco?

   Yes_____ No_____

   State brand(s) smoked or chewed:_____

   State amount smoked/utilized:_____ cigars/pipes/smokeless tobacco per day for _____years, during the years _____ to _____.

4. Alcohol and Allergies

   a. For the period of time five years before your first hip surgery up to the present, set forth the amount and type(s) of alcoholic beverages you consume(d) on a weekly/monthly/yearly basis on average and the type. If the amount has materially changed over this period of time, please describe/explain. _____

b. Have you ever experienced an allergic reaction to any food, medication, jewelry, or metal?

Yes_____ No_____

If yes, please state the following:

Food, Medication, Jewelry or Metal	When Allergy Diagnosed	Symptoms of Allergy	Health Care Provider Who Diagnosed Allergy	Treatment Received, if any

5. Other Conditions

a. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions from the time beginning five years before your first hip surgery to the present? Please select Yes or No for each condition. For each condition for which you answer Yes, please provide the additional information requested in the table following this chart:

Condition Experienced or Diagnosed	Yes	No	Don't Know	Symptoms	Date of Diagnosis
1. Arthritis (e.g., osteoarthritis, traumatic arthritis, rheumatoid arthritis, degenerative arthritis)					
2. Neuromuscular compromise or vascular deficiency					
3. Poor bone quality (e.g., osteoporosis)					
4. Bone or musculature issues					
5. Renal insufficiency					
6. Charcot's or Paget's disease					
7. Cancer (including blood cancers such as leukemia)					

Condition Experienced or Diagnosed	Yes	No	Don't Know	Symptoms	Date of Diagnosis
8. Allergy, such as hay fever, asthma, eczema, hives, sensitivity to drugs or other substances, including allergic reactions to metal					
9. Obesity					
10. Alcohol or drug addiction					
11. Any pathological condition of the acetabulum (e.g., arthrokatadysis)					
12. Diabetes					
13. Bladder issues					
14. Groin pain					
15. Infections lasting longer than a week or occurring more frequently than monthly					
16. Blood clots					
17. Tumors or Pseudo-tumors					
18. Periarticular calcification or ossification					
19. Disabilities of joints (knees and ankles)					
20. Osteolysis					
21. Congenital dysplasia of the hip or subluxation or dislocation of the hip joint					
22. Peripheral neuropathies or nerve damage					
23. Acetabular perforation					
24. Femoral shaft perforation, fissure, or fracture					

Condition Experienced or Diagnosed	Yes	No	Don't Know	Symptoms	Date of Diagnosis
25. Trochanteric fracture					
26. Aseptic lymphocyte-dominated vasculitis-associated lesion (ALVAL)					
27. Adverse local tissue reaction (ALTR)					
28. Adverse reaction to metal debris (ARMD)					
29. Metallosis					

b. For each condition for which you answered Yes in the previous chart, please provide the information requested below:

Condition You Experienced	Approximate Date of Onset	Name, Address and Telephone Number of Treating Physician (if any)	Treatment Received

VI. MEDICATIONS

Instructions: If the below information is not included in your medical records, or if you have additional information beyond your medical records, please fill in appropriately. Otherwise, please make reference to the appropriate medical records for the information.

1. List all of the medications (prescription and over the counter) you currently take.

Medication	Dose/Frequency/ Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

2. To the best of your recollection, are there any prescription medications other than those identified that you have taken on a regular basis for any duration of more than two months for the period five years before your first hip surgery to the present? (except for treatment for any orthopedic condition or complaint about your hips, legs or pelvis, in which case information should be provided for the past ten years.)

   Yes_____ No_____

   If yes, please identify the medication(s), the doctor(s) who prescribed it, the approximate dates/years you have taken this medication, and why it was given to you:

Medication	Dose/ Frequency/Dates of Use	Physician Ordering	Pharmacy Dispensing	Purpose

VII. IMPLANT/REMOVAL

1. Describe the condition for which the M²a Device was implanted:_____
_____
_____

a. Is this condition the result of an on-the-job injury? Yes_____ No_____

If yes, please state:

Place of employment at the time:_____

Address:_____

Telephone number:_____

Job description/duties at the time:_____
_____

Nature of accident:_____

2. Before the implantation of the M²a Device, did you receive non-surgical treatment for your hip? Yes_____ No_____

If yes, please provide the following information:

a. State the period during which you received non-surgical treatment:_____
_____

b. State the nature of the non-surgical treatment (e.g., rest, physical therapy, medication, injections): _____
_____
_____

c. State the name and address of all doctors or health care providers involved in your non-surgical treatment:_____
_____
_____

3. Did you see, read or rely upon any documents or other information from Biomet in making your decision to have the M²a Device implanted? Yes_____ No_____

a. If yes, identify each document/source of information._____
_____

b. When did you read the document/receive the information?_____
_____

c. How did you obtain the document or information?_____

_____

d. Do you have the document or written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet.

Yes_____ No_____ I don't know_____

If you no longer have the document or written information in your possession, please describe the information that you received to the best of your ability:

_____

4. Were you given any verbal or written instructions, warnings or other information regarding the implantation of the M²a Device? Yes_____ No_____ I don't know_____

a. If yes, when did you receive the information?_____

b. Who gave you the information?_____

c. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff Fact Sheet.

Yes_____ No_____ I don't know_____

d. Please describe the oral instructions/warnings you received to the best of your ability: _____

_____

_____

5. Have you had any communications with any present or former employee of Biomet any other defendant companies or these companies' distributors or sales representatives concerning the M²a Device or matters in any way related to this lawsuit?

Yes_____ No_____

If Yes, for each, please state:

Date of Communication	Name of Person with Whom You Communicated	Mode of Communication (In Person, By Phone, By Email, By Mail)	Do you have a writing or recording? (IF SO, PLEASE ATTACH)

If the communication was by phone or in-person, please tell us what was said:_____

_____

VIII. INJURIES & DAMAGES

NOTE: IF THE BELOW INFORMATION IS INCLUDED IN YOUR MEDICAL RECORDS, YOU MAY MAKE REFERENCE TO THE MEDICAL RECORS FOR THE INFORMATION.

1. Are you claiming any physical injuries or illness as a result of the M²a Device?

Yes_____ No_____

If yes, please describe in detail the following:

a. The physical injuries or illness claimed and when the symptoms began:_____

_____

_____

_____

_____

_____

_____

_____

b. Are those injuries or illnesses continuing? Yes_____ No_____

c. Provide the approximate date of treatment for each condition, and identify the name and address of each health care provider that you have seen for these problems:

Condition You Experienced	Approximate Date of Treatment	Name, Address and Telephone Number of Health Care Provider (if any)

d. Have you ever been hospitalized as a result of any of these conditions?

Yes_____ No_____. If Yes, please provide the following information:

i. Approximate date(s) of hospital admission:_____

_____

ii. Approximate date(s) of discharge: _____

_____

iii. Hospital names(s) and address(es):_____

_____

_____

2. Do you claim any psychological or psychiatric injury as a consequence of having the M²a Device? Yes_____ No_____

If yes, please state the following as it pertains to your treatment for any psychiatric and/or psychological condition(s):

Condition	Name and Address of Mental Healthcare Provider (if any)	Approx. Dates/Years of Treatment/Visits (if any)

3. Are you making a claim for lost wages or lost earning capacity? Yes_____ No_____

a. If yes, describe your claim and attach your W-2 forms for the past (5) years. Your description should include the total amount of time (and amount of income) which you have lost or will lose from work as a result of any condition which you claim or believe was caused by the M²a Device, and an explanation of how those amounts were calculated: _____

_____

_____

_____

_____

_____

b. If you claim a loss of earnings, state your earned income from work for the following years:

Year	Income
2012	$
2011	$
2010	$
2009	$
2008	$
2007	$

IX. MEDICAL AND OUT-OF-POCKET EXPENSES

1. State the amount of medical expenses, by provider, that you have incurred, including amounts billed to insurers and other third party payors, which are related to any condition thhat you claim or believe was caused by the M²a Device for which you seek recovery in this action:

Name and Address of Provider	Dates of Treatment	Amount of Medical Expenses
		$
		$
		$
		$
		$

For any expenses claimed above, have they been reimbursed by any third party?

Yes_____ No_____

If yes, identify which expenses, the amount reimbursed and the date reimbursed.

_____

_____

_____

_____

X. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. Are you filling this out on behalf of an individual who is deceased? Yes_____ No_____

If yes, please state the following from the Death Certificate of the individual, and attach a copy of the letter of administration: (NOTE: In lieu of the following, please attach a copy of the death certificate)

Date of death:_____

Place of death (city, state and country):_____

Facility or location where death occurred:_____

_____

Name of physician who signed death certificate:_____

Cause of death:_____

2. Are you filling this out on behalf of an individual who is deceased and on whom an autopsy was performed? Yes_____ No_____

If yes, please attach a copy of the autopsy report.

XI. FACT WITNESSES

Please identify all persons whom you believe possess information concerning you injury(ies) and current medical conditions, other than your healthcare providers, and please state their name, address, and relationship to you:

Name:_____

Address:_____

Relationship to you:_____

Name:_____

Address:_____

Relationship to you:_____

Name:_____

Address:_____

Relationship to you:_____

Name:_____

Address:_____

Relationship to you:_____

Name:_____

Address:_____

Relationship to you:_____

Name:_____

Address:_____

Relationship to you:_____

XII. DOCUMENT DEMANDS

These document requests are not intended to seek attorney client communications, or attorney work product materials. In addition, these requests do not encompass or seek information about expert witnesses or communications with and/or from experts or proposed trial exhibits or trial materials which may be subject to disclosure at a later date in accordance with subsequent Court Order or rule. If you have any of the following in your possession which is not protected as set forth above, please provide a copy of it with this Plaintiff Fact Sheet.

REQUEST NO. 1: With respect to any injury, illness and/or disease identified in response to this Plaintiff Fact Sheet, produce all medical records in your possession from any physician, hospital or health care provider.

REQUEST NO. 2: All radiographs (x-rays, ultrasounds, MRIs, CT scans) that relate to the condition and injuries alleged in your complaint or that show any portion of your hip and/or depict the M²a Device.

REQUEST NO. 3: All laboratory reports and results of blood tests performed on you that shows the level of cobalt and chromium ion levels in the blood.

REQUEST NO. 4: All medical bills for which you seek recovery in this lawsuit, as well as all documents relating to third-party payments of medical bills.

REQUEST NO. 5: All records of any other expenses allegedly incurred as a result of the injuries alleged in the complaint.

REQUEST NO. 6: All photographs and videos of your surgery and all photographs and videos of you which show your condition since the date of the original implantation.

REQUEST NO. 7: Any documents including but not limited to literature or warnings received by you from surgeons, physicians, or other health care professionals who have treated you for any condition related to the M²a Device.

REQUEST NO. 8: Any documents including diaries, journals, calendars, emails, texts, postings on websites, blogs, and social media accounts (e.g. Facebook, MySpace, or Twitter) or

other notes prepared by you or your representative, other than your attorneys, concerning Biomet, the M²a Device, and your physical and emotional health.

REQUEST NO. 9: All materials you received concerning the nature of the M²a Device, whether created by Biomet, your health care provider, or any other third party.

REQUEST NO. 10: Decedent's death certificate, letter of administration, and/or autopsy report (if applicable).

REQUEST NO. 11: All bankruptcy petitions and orders of discharge (if applicable) for all bankruptcy claims made by you or your spouse since the date of your first hip surgery.

XIII. AUTHORIZATIONS

Complete and sign the attached Authorizations.

XIV. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge upon information and belief, that I have supplied all the documents requested in part XII above, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and that I have supplied the authorizations attached to this declaration.

Date:_____

Signature:_____

Printed Name:_____

General Information

Court	United States District Court for the Northern District of Indiana; United States District Court for the Northern District of Indiana
Federal Nature of Suit	Personal Injury - Product Liability[365]
Docket Number	3:12-md-02391