Appendix B

Notice of Intent to Opt In Form for Filed Claims

Notice of Intent to Opt In Form for Filed Claims

INSTRUCTIONS

THIS FORM APPLIES TO ALL PLAINTIFFS WITH CLAIMS:

1. **PENDING IN ANY STATE OR FEDERAL COURT THAT WERE FILED AND SERVED ON OR BEFORE APRIL 28, 2015; AND**
2. **ALLEGING BLADDER CANCER INJURIES RESULTING FROM THE USE PRIOR TO DECEMBER 1, 2011 OF ACTOS PRODUCTS.**

IF YOU WISH TO PARTICIPATE IN THE ACTOS RESOLUTION PROGRAM (the "Program") AND TO BE POTENTIALLY ELIGIBLE FOR AN AWARD UNDER THE PROGRAM, YOU MUST SUBMIT THIS FORM AS PART OF THE OPT IN PACKAGE FOR FILED CLAIMS ON OR BEFORE 11:59 p.m. CT ON JULY 13, 2015 (UNLESS EXTENDED TO A LATER DATE PURSUANT TO THE TERMS OF THE SETTLEMENT AGREEMENT), IN ACCORDANCE WITH SUBMISSION INSTRUCTIONS PROVIDED BY THE CLAIMS ADMINISTRATOR. *SEE* WWW.ACTOSOFFICIALSETTLEMENT.COM.

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NOTICE OF INTENT TO OPT IN FORM FOR FILED CLAIMS

By timely submitting this form:

1. You agree to be bound by the terms of the Master Settlement Agreement and the jurisdiction of the Special Master and the MDL Court, the California Coordinated Proceeding Court, or the Illinois Coordinated Proceeding Court, as applicable, with regard to all matters pertaining to the Master Settlement Agreement and the Program contained therein. The Master Settlement Agreement is available for review at www.ActosOfficialSettlement.com.
2. You acknowledge that upon your election to participate in the Program, Takeda shall be entitled to the dismissal of your pending case relating to ACTOS personal injuries, either by submission of the Stipulation of Dismissal submitted herewith, or upon motion to dismiss made to the Special Master, who will make recommendations to the court in which your case is pending. You acknowledge that upon your election to participate in the Program, Takeda shall be entitled to present the Release submitted herewith in any relevant action or proceeding.
3. You acknowledge that you will not be eligible for an award unless you also timely submit a completed Claim Package that meets the requirements set forth in the Master Settlement Agreement.
4. You acknowledge that appeals of determinations by the Claims Administrator as to whether a Claimant is eligible for payment and the amount of such payment under the terms of the Settlement Agreement will be resolved by the Special Master, and that the Special Master's decisions will be binding on the parties.
5. By checking the box below and executing this form, you acknowledge that you have been fully advised of your rights under the Master Settlement Agreement and elect to participate in the Program, and that such election is irrevocable.

☐ **I elect to participate in the ACTOS Resolution Program.**

ACTOS Product User INFORMATION

ACTOS Product User Name	Last	First	Middle
Product User Social Security Number	______ - ____ - ________		
Case Number and Jurisdiction			
Address	Street		
	City	State / Zip	Country
Telephone Number (_____) ______-_______	**Email:** ____________________		
Alleged Injury (check all that apply)	☐ **Bladder Cancer** ☐ **Bladder Cancer with Recurrence**	☐ **Bladder Cancer Resulting in Full or Partial Cystectomy** ☐ **Wrongful Death**	
Product User Date of Birth (Month, Day, Year) ____/____/_____	**Date of Alleged Injury (Month/Day/Year)** ____/____/_____		
Date of Alleged First ACTOS Products Usage (Month, Day, Year) ____/____/_____	**Date of Alleged Last ACTOS ProductsUsage (Month, Day, Year)** ____/____/_____	**Alleged Dosage of ACTOS Products:** ________________	**State of Residence at Time of Injury** ____________

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ATTORNEY INFORMATION (If Applicable)					
Attorney Name	Last		First		Middle
Firm Name					
Address	Street				
	City	State	Zip		Country
Telephone Number	(_____) ______-____________		**Facsimile**	(_____) ______-____________	
Email					

CLAIMANT'S SIGNATURE IMPORTANT: This form must be signed by Claimant (the ACTOS Product User or the legal representative of a deceased or incapacitated product user). If submitted online, an electronic signature is acceptable in accordance with the instructions of the Claims Administrator.				
Signature			**Date**	_____/_____/_____ (month) (day) (year)
Printed Name	First	MI	Last	

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