Appendix H-2

Notice of Potential Third-Party Claimants

NOTICE OF POTENTIAL THIRD-PARTY CLAIMANTS

A. NOTICE TO PROGRAM PARTICIPANT

1. Name	Last	First	Middle Initial

2. Date of Birth	____/____/____ (MM/DD/YYYY)	**3. Social Security Number**	|__|__|__| - |__|__| - |__|__|__|__|

B. PROGRAM PARTICIPANT'S COUNSEL

4. Legal Counsel's Name	Last	First	Middle Initial

C. ADDITIONAL THIRD-PARTY CLAIMANTS

Instructions: You are receiving this Notice because Organon or the Claims Administrator have identified additional actual or potential insurers and/or known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors. The omitted Potential Third-Party Claimants are listed below.

Insurer/Plan Name	**Policy/Plan Number(s).** (Include copy of Insurance Card)	**Dates of Coverage/ Eligibility**	**Policyholder/ Subscriber Name**	**Coverage Description (Primary/Secondary/ Supplemental)**

Known Third-Party Claimants	**Address**	**Description of Claim**

D. NOTICE OF RESPONSIBILITY TO IDENTIFY OR AMEND

Upon receipt of this Notice, the above-identified Program Participant and their counsel must amend their Identification of Third-Party Claimants to include the additional Potential Third-Party Claimants identified in this Notice. Any Amended Identification of Third-Party Claimants shall be resubmitted to the Claims Administrator within ten (10) days of receipt of this Notice.

Program Participant and their counsel assume all responsibilities and obligations to satisfy or resolve these interests before any payment will be made.