IN RE: PROPULSID® PRODUCTS LIABILITY LITIGATION

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

MDL NO. 1355

SECOND MDL RESOLUTION PROGRAM

CLAIM FORM
FOR ALLEGED WRONGFUL DEATH (TIER I)

TO BE FILLED OUT BY PLAINTIFF OR CLAIMANT (WITH OR WITHOUT ASSISTANCE OF COUNSEL)

I.
AGREEMENT AND INSTRUCTIONS

A. This form is to be used for submitting alleged wrongful death claims by or on behalf of any Propulsid® Plaintiff in a lawsuit filed on or before November 15, 2005, (hereafter, "Plaintiff"), or by or on behalf of any Propulsid® claimant on a signed Tolling Agreement (including Plaintiffs in the Master Complaint of Louisiana Propulsid® Claimants, known as the Achord action, filed in the USDC, E. Dist. of LA) (hereafter, "Claimant") who has timely enrolled in the Second Propulsid® MDL 1355 Resolution Program (hereafter, the "Second Program") as described in the MDL 1355 Second MDL Term Sheet dated December 15, 2005, which is incorporated herein in its entirety.

B. To properly submit this Claim Form, read the Claim Form in its entirety and answer all of the inquiries in it on the Claim Form itself [and add additional sheets if necessary] and then sign and date the Claim Form [and all additional sheets] and complete a Certificate of Service of the Claim Form in a format similar to that contained in the template Certificate of Service of Claim Form located at Attachment B; and:

C. It is recognized that there may be conditions which prevent you from providing all the information sought in this claim form and in providing all the required medical records. However, your vigorous diligence in providing that information and in providing those records is required. The Medical Review Panel has the discretion to approve or deny your claim based on the information that you submit.

D. Serve complete copies of:

- the completed, signed and dated Claim Form; and

- the signed and dated Certificate of Service of Claim Form describing the manner of service as follows:

All originals to the office of the Program's Special Master:
Special Master's Office
400 Poydras Street, Suite 2820
New Orleans, LA 70130
Phone: (504) 586-7995
Fax: (504) 586-1998

E. You must submit this Claim Form and serve it in the manner described below within 120 days of service of notice by the Plaintiffs' Steering Committee ("PSC") and/or State Liaison Committee ("SLC") that the Program's minimum enrollment levels have been reached, or within 120 days of service of your enrollment form, whichever is later.

F. Within 60 days after service of your Claim Form, you must submit all required medical records for review, unless pursuant to Section 7 of the Term Sheet, upon application to the special master, you have demonstrated a good faith effort to secure the medical records, then the period for securing records shall be extended for an additional 60 days. (see Attachment A to this Claim Form for a description of the 'medical records requirements' contained in Section 2 of Exhibit A to the Term Sheet.)

G. If you fail to submit the medical records required to process your claim within 60 days after you serve your Claim Form, then subject to the exception in Section 7 of the Term Sheet allowing for an additional 60 days to secure records upon a showing of good faith effort to secure the records (made by application to the special master), your claim shall be dismissed in its entirety with prejudice. No further action is to be taken on it and no litigation may be commenced or maintained to attempt to pursue that or any other Propulsid®-related claim.

H. Within 60 days of submission of your medical records, the parties may simultaneously submit to the medical panel confidential memoranda explaining the parties' contentions as to your decedent's qualification or non-qualification under the program and the category under which the claim is submitted. Pursuant to Section 13 of the Term Sheet, said memorandum is not to exceed five pages; exhibits to the memorandum may be abstracts or full documents not to exceed thirty pages. No expert reports or affidavits shall be submitted. (see Section 13 of the Term Sheet for details.)

I. You also acknowledge that before you will be paid any award you may be granted under this Program, you shall be required to provide Lead Counsel to Defendants with the information with which to draft any further documentation required by the Term

Sheet. Once those documents are prepared, you must execute and return them to Lead Counsel for Defendants. The prerequisites to your receiving payment of any award to which you are deemed entitled under this Program include but are not limited to the following:

1. With respect to alleged wrongful death claims arising in states which limit the right to file and/or settle a wrongful death claim to those persons appointed by a local state court to maintain and/or settle such a claim, the Plaintiff/Claimant submitting an alleged wrongful death claim under this Program must represent and warrant that they have been appointed by court order as the proper representative, and said Plaintiff/Claimant must present proof of such appointment (e.g., a copy of the operative court order or Letters of Administration) to Lead Counsel for Defendants; and

2. With respect to claims that fall into the description contained in the immediately preceding paragraph, to the extent the requisite court appointment has not been obtained, Plaintiff or Claimant hereby agrees that no award to which they might be entitled under this Program shall be paid until proof is provided to Lead Counsel for Defendants that the Plaintiff or Claimant has since obtained the requisite court appointment (and that all necessary follow-up steps, such as substitution of the proper party into any filed lawsuits, have occurred); and

3. With respect to alleged wrongful death claims arising in states that do not require court appointment of a designated representative to file and/or settle a wrongful death claim, but instead limit the right to file and/or settle a wrongful death claim to a particular heir or heir(s), albeit without court appointment, the Plaintiff/Claimant enrolling in this Program must represent and warrant to the satisfaction of Lead Counsel for Defendants that under applicable state law, he or she is one of the statutory heirs who has the right to file and/or settle a wrongful death claim arising out of decedent's death; and

4. With respect to claims that fall into the description contained in the immediately preceding paragraph, if the Plaintiff or Claimant who enrolled in this Program is not one of the statutory heirs with the right under state law to file and/or settle a wrongful death claim without court appointment, no award reached under this Program shall be paid until proof is presented to Lead Counsel for Defendants that the proper heir has been substituted as a party to any existing lawsuits and has been enrolled in this Program; and

5. In addition to the above requirements, before an award will be paid on any wrongful death claim, you must identify by full name, relationship to decedent, date of birth and Social Security number all statutory heirs (persons who, under applicable state law, had or have the right to file a wrongful death claim as a result of decedent's death or are those entitled to share in any settlement proceeds). Moreover, all statutory heirs must comply with the provisions of the Term Sheet before any award will be paid.

J. You also acknowledge that pursuant to Section 20 of the Term Sheet, upon submitting the requisite Claim Form, you must state whether or not you have reached a settlement with an entity other than the Janssen and Johnson & Johnson defendants. You also agree that if it is determined that you are eligible for an award payment, you must inform the Special Master exclusively of the amount of any such settlement.

K. By having enrolled in this Program, you acknowledged that the decisions of the Medical Panel and Special Master may be ones with which you disagree, but further acknowledge that this eventuality is part of the Program, and you accepted that eventuality by having authorized your attorney to enroll you in the Program. You further specifically agree that the decisions of the Medical Panel and Special Master are final and not appealable.

L. It is acknowledged that, having enrolled in this Program, you thereby surrendered your rights to litigate your case and any other claims and potential claims relating in any way to Propulsid®, including but not limited to all claims, liabilities, demands, actions, suits and causes of actions for damages (including but not limited to current and future causes of action for wrongful death, and current and future causes of action for personal injury and loss of consortium), restitution, disgorgement, unjust enrichment, civil penalties, statutory penalties, injunctive and/or declaratory relief, whether class, individual, representative or otherwise in nature, including costs, expenses, penalties, and attorneys' fees, known or unknown, suspected or unsuspected, in law or equity, that accrued prior to the date of enrolling in the Program that you ever had, now have or hereafter can, shall or may have, which has been asserted or could have been asserted in the MDL or in any other action, and you acknowledge that having enrolled in the Program, you unconditionally, fully and forever released whatever rights you and your decedent's heirs and representatives may have had, or may ever have, against defendants Johnson & Johnson, Janssen, L.P., Janssen Pharmaceutica Inc. and Janssen Pharmaceutica, N.V., all health care professionals, health care providers, health care facilities, pharmacies and other distributors of Propulsid®, and their parents and subsidiaries, affiliates, agents, attorneys, servants, employees, officers and directors and those who may have acted in concert with them, together with their respective insurers relating to your decedent's alleged ingestion of Propulsid®. You also acknowledge that when you enrolled in the Program, you were authorized to release the aforementioned claims on behalf of yourself and decedent's heirs, beneficiaries and representatives and that you waived California Civil Code Section 1542, if applicable, which provides that, "a general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor." You also acknowledge that if the Medical Panel determines that you are entitled to an award under this Program, you must comply with all of the provisions of the Term Sheet prior to payment of such award, including but not limited to preparing any documentation called for under the Term Sheet for finalizing payment of the award.

Attorneys for Claimants and/or Plaintiffs shall provide a completed W-9 Form, a copy of which is attached hereto as Attachment D, which form shall provide, among other things, the appropriate tax identification number for that attorney.

M. The signatories to the Claim Form, the law firms with which they are affiliated and the Plaintiffs and Claimants identified on Attachment A specifically agree to maintain the confidentiality of any awards of compensation that might result from the Program.

N. You agree to execute and serve with this Claim Form the original Authorization to Release Medical Records attached hereto as Attachment C.

II.
CLAIM FORM FOR WRONGFUL DEATH (TIER I) CLAIM

A. ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, AS NECESSARY, ATTACH ADDITIONAL SHEETS:

1. Decedent Information:

a. Current name and other names (e.g., maiden names, married names) used by now-deceased alleged Propulsid® user for the ten years prior to death (last name first, followed by first name and middle initial):

_____

b. Decedent's Last Known Residence Address:

_____

_____

_____

c. Decedent's Date of Birth: _____

d. Decedent's Date of Death: _____

e. Decedent's Social Security Number: _____

2. Plaintiff(s)'/Claimant(s)' Information for all Plaintiffs/Claimants Submitting this Claim re: the above-listed Decedent [attach separate sheet(s) as necessary to answer all of the following questions re: each Plaintiff/Claimant]:

a. Current name and other names used by each Plaintiff/Claimant at the time of and subsequent to Plaintiff's filing of Propulsid® lawsuit re Plaintiff's decedent or at the time of or subsequent to Claimant entering into a Tolling Agreement or joining the Achord action with respect to Claimant's decedent (last name first, followed by first name and middle initial):

_____

b. Plaintiff's/Claimant's Current Residence Address:

_____

_____

_____

c. Date of Birth: _____

d. Social Security Number: _____

e. Relationship to Decedent: _____

f. Details re: relationship to Decedent (whether Plaintiff/Claimant is the court-appointed representative of Decedent's estate, etc.): _____. If a court-appointed representative, please attach copies of the Letters of Administration or other court orders making such appointment.

3. Decedent's Alleged Propulsid® Use:

a. Date(s) ingested: _____

b. Dosage(s) ingested (amount (e.g., 20 mg.) and number daily):
_____/_____

c. Ordering Physician(s) Name(s), Addresses and Phone Numbers:

_____

d. Pharmacies where all Propulsid® Prescriptions were ever filled (names, addresses and phone numbers of all such pharmacies):

_____
_____
_____

4. Other Medications Used by Decedent:

a. For each prescription medication ingested by decedent during the three years prior to the adverse event leading to decedent's death (or during decedent's entire life if decedent was under age 12 at time of death), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

b. For each over-the-counter medication ("OTC") medication ingested by decedent during the three months prior to the adverse event leading to decedent's death (or during decedent's entire life if decedent was under age 12 at time of death), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

5. Alleged Adverse Event/Injury:

a. Date of Adverse Event Allegedly Leading to Decedent's Death: _____

b. Description of Nature of Adverse Event Allegedly Leading to Decedent's Death: _____

c. Names, Addresses, Telephone Numbers of Physician(s), Physician's Assistants and Nurse Practitioners who treated Decedent for the alleged injuries or adverse event he or she suffered that are being attributed to Decedent's alleged ingestion of Propulsid® and the dates of such treatment from the date of the alleged injury to date of death. (Include names, addresses and phone numbers of any pertinent treatment facilities, including but not limited to hospitals, ambulance or paramedic companies, fire department rescue crews, police and sheriff investigators, medical examiners and the issuers of autopsy reports and death certificates.)

_____

_____

_____

6. Medical Treatment History:

a. For all medical treatment, of any kind, received by Decedent in the one year prior to death from any type of medical practitioner (doctors, physician's assistants, nurse practitioners, therapists, hospitals, clinics, pharmacies, ambulance services, paramedic companies and home health services) provide for each:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

b. For each of Decedent's emergency room visits and hospitalizations during the three years preceding Decedent's Adverse Event/Death (or for a decedent who was less than age 12 at time of death, for their entire life), provide the following:

(i) facility name;

(ii) facility address;

(iii) condition leading to hospitalization;

(iv) dates of admission; and

(v) duration of hospitalization.

c. For all of the following cardiac studies ***excluding* ECGs** (see 6.e. below re ECGs), performed during the three years before Decedent's alleged adverse event (or if decedent was under age 12 at time of death, during decedent's entire life), ***including*** holter monitoring, stress tests, heart scans, echo-cardiograms, cardiac angiography/catheterization, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

d. For the three years prior to Decedent's alleged adverse event (or if Decedent was under 12 at the time of the adverse event, during Decedent's entire life) for all treatment received by Decedent from Decedent's primary care physician(s), cardiologist(s), gastroenterologist(s) and/or pediatrician(s), provide:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

e. For the ten years prior to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life) for each ECG, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

f. For the ten years prior to the adverse event allegedly related to Decedent's Propulsid® use and allegedly leading to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life), provide the following for all hospital records where cardiac concerns were implicated. Cardiac concerns include but are not limited to chest pain or angina, syncope (fainting or near fainting), heart attack, congestive heart failure, hypertension, cardiomyopathy, valvular disease, infections of the heart or heart valve and myocarditis.

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

g. For the ten years prior to the adverse event allegedly related to Decedent's Propulsid® use and allegedly leading to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life), provide the following for all hospital records where GI concerns were implicated:

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

h. For each insurance or other company that provided medical bill coverage for Decedent's health care for treatment of Decedent's alleged Propulsid-related adverse event from the date of said adverse event through the date of Decedent's death.

(i) company name of insurer;

(ii) address and telephone number; and

(iii) dates of coverage.

i. If any of decedent's medical expenses relating to his/her alleged ingestion of Propulsid® were covered by Medicare, Medicaid or military benefits, i.e., V.A. or Tri-Star, so state, and describe any medical liens of which you are aware:

_____

7. **Economic Losses:**

List all economic losses you are claiming, including but not limited to lost wages, and in the event you are claiming economic loss in the form of lost wages, provide the name and address of decedent's employer, decedent's title at his or her place of employment and decedent's dates of employment claimed to have been lost due to Propulsid® use:

_____

_____

_____

8. Propulsid®-Related Settlements With Other Third Parties:

a. State whether you have reached a settlement with any other party besides one of the Janssen or Johnson & Johnson defendants, e.g., including but not limited to with a doctor, hospital, pharmacy, or insurer:

_____

b. If you answered "yes" to question II.8.a. above, identify the name of the person and/or entity with whom the settlement was reached:

9. Pendency of Propulsid® Lawsuits and/or Claims:

a. State whether you are involved in any pending Propulsid®-related lawsuit or claim other than the one for which you are submitting this Wrongful Death Claim Form:

_____

b. If you answered "yes" to question IV.9.a. above, describe the name of, venue of, docket number (if a filed lawsuit) and parties to the lawsuit(s) and/or claim(s):

_____

_____

_____

B. COMPLETE, SIGN AND DATE CERTIFICATE OF SERVICE OF CLAIM FORM FOR WRONGFUL DEATH (TIER I) CLAIM IN THE FORM CONTAINED IN THE TEMPLATE CERTIFICATE OF SERVICE IN ATTACHMENT B.

C. SIGN AND DATE BELOW.

Dated: _____ [Plaintiff's/Claimant's Signature]
[Representative of Decedent]
Printed Name of Plaintiff/Claimant Rep
Printed Residence Address

Dated: _____ [Signature of Plaintiff's/Claimant's Attorney
Printed Individual Attorney Name
Law Firm Name, Address, Telephone/Fax