ATE RESOLUTION PROGRAM
NOTICE OF INTENT TO OPT IN FORM

INSTRUCTIONS

THIS FORM APPLIES TO:

1. **Claimants <u>with</u> lawsuits relating to DCOCs pending in any court on August 3, 2015 who allege ATE injuries after the use of drospirenone-containing oral contraceptives manufactured by Bayer or manufactured or marketed by Barr Laboratories, Inc. or Teva Pharmaceuticals USA, Inc. ("DCOCs").**

AND TO:

2. **Claimants <u>without</u> lawsuits relating to DCOCs pending in any court on August 3, 2015 who allege ATE injuries after the use of DCOCs and had retained an attorney or law firm relating to those injuries on or prior to August 3, 2015.**

IF YOU WISH TO PARTICIPATE IN THE ATE RESOLUTION PROGRAM AND TO BE POTENTIALLY ELIGIBLE FOR AN AWARD UNDER THE PROGRAM, YOU MUST, AMONG OTHER THINGS, SUBMIT THIS FORM ON OR BEFORE 11:59 P.M. C.T. ON <u>SEPTEMBER 12, 2015</u> (UNLESS EXTENDED TO A LATER DATE PURSUANT TO THE TERMS OF THE MASTER SETTLEMENT AGREEMENT), IN ACCORDANCE WITH THE INSTRUCTIONS PROVIDED BY THE CLAIMS ADMINISTRATOR. *See* <u>WWW.YAZOFFICIALATESETTLEMENT.COM</u> FOR MORE INFORMATION.

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By timely submitting this form, the Claimant or authorized representative of a deceased, incapacitated, or minor DCOC Product User, agrees and acknowledges as follows:

1. I agree to be bound by the terms of the Master Settlement Agreement and the jurisdiction of the Special Master with regard to all matters pertaining to the Master Settlement Agreement and the Program contained therein. The Master Settlement Agreement is available at www.yazofficialatesettlement.com.
2. I acknowledge that I will not be eligible for an award and my case (if one is filed) will be dismissed with prejudice if I do not submit a timely and complete Claim Package.
3. I 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 Master Settlement Agreement, will be resolved by the Special Master, and that the Special Master's decisions will be binding on the parties with no right to appeal.
4. I acknowledge that I have been fully advised of my 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 ATE Resolution Program.**

DCOC PRODUCT USER INFORMATION

DCOC User Name	Last	First	Middle
DCOC User Social Security Number	|___|___|___| - |___|___| - |___|___|___|___|		
Case Number and Jurisdiction (if applicable)			
Address	Street		
	City	State / Zip / Country	

Telephone Number
(_____) _____-_____

Email: _____

Alleged ATE Injury (check all that apply)

☐ **Ischemic Stroke**
☐ **Transient Ischemic Attack**
☐ **Myocardial Infarction**
☐ **Other Adverse Cardiovascular Event:** _____

Product User Date of Birth (Month, Day, Year)	**Date of Alleged ATE Injury (Month/Day/Year)**
____/____/_____	____/____/_____

Date of Alleged First DCOC Product Usage (Month, Day, Year)	**Date of Alleged Last DCOC Product Usage (Month, Day, Year)**	**State of Residence at Time of Injury**
____/____/_____	____/____/_____	_____

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NOTICE TO CLAIMANTS <u>WITHOUT LAWSUITS PENDING</u>
IN ANY COURT ON AUGUST 3, 2015

Claimants with no lawsuit pending relating to an ATE injury after use of DCOCs in any court on August 3, 2015, must timely submit this Form to participate and be potentially eligible for an award in the Program AND the following:

1. **For Claimants not identified on a Case Census, a Declaration of Counsel contained in Appendix D of the Master Settlement Agreement, to be submitted by Claimant's counsel, certifying that the DCOC Product User (or her personal representative) retained counsel (or his or her law firm) on August 3, 2015 for legal representation relating to an ATE Injury after the use of DCOCs.**

2. **An executed Release contained in Appendix C-1 of the Master Settlement Agreement. In the event any person asserts a Derivative Claim, an executed Release contained in Appendix C-2 of the Master Settlement Agreement executed by the Program Participant and by any person who asserts a Derivative Claim.**

ATTORNEY INFORMATION (If Applicable)

Attorney Name	Last	First		Middle
Firm Name				
Address	Street			
	City	State	Zip	Country
Telephone Number	(_____) _____-_____	**Facsimile**	(_____) _____-_____	
Email				

CLAIMANT SIGNATURE

IMPORTANT: This form must be signed by Claimant (the DCOC Product User or the authorized representative of a deceased, incapacitated or minor DCOC Product User). Primary Counsel may sign this form on behalf of the Claimant by following the online instructions for electronic signature.

Signature			**Date**	_____/_____/_____ (month) (day) (year)
Printed Name	First	MI	Last	
Signing For:	☐ **Product User**	☐ **Representative Claimant of Deceased, Incapacitated or Minor Product User**		