Appendix D

Claimant: _____
(name)

CLAIM FORM

The Claim Package, including a completed copy of this Claim Form, must be submitted no later than the Claim Package Deadline on behalf of all Claimants, including unrepresented (*pro se*) Claimants, in the Gallbladder Resolution Program (the "Program") outlined in the Settlement Agreement of March 15, 2013 (the "Agreement").

Counsel for Claimants, and all *pro se* Claimants, must complete Sections I, II, III, IV, V, and VI of this Claim Form.

I. CASE INFORMATION

A. Information Regarding Claimant:

_____
Name

_____
Address

_____
Telephone Number

_____
Social Security Number

_____
Date of Birth

_____
Any other names by which Claimant has been known, including but not limited to maiden name

B. Information Regarding Primary Attorney:

_____
Name of Attorney

_____
Firm Name

_____
City, State and Zip Code

_____
Telephone Number

_____
Telecopy Number

_____
E-mail Address

C. Information Regarding Case**:**

_____
Court/Jurisdiction

_____
Case Caption

_____
Case No.

II. PERSONAL REPRESENTATIVE INFORMATION FOR DECEASED OR INCAPACITATED CLAIMANTS

A. Does the Claimant have a representative? _____Yes _____No
(If Yes, complete this Section II, if No, Skip to Section III.)

B. Relationship to Claimant: _____

C. Last Name: _____
First Name: _____
Middle Name or Initial: _____

D. Address: _____

E. Telephone Number: _____

F. Social Security Number: _____

G. Date of Birth: _____

H. Date of Death of Claimant (if applicable): _____ Do you claim Product caused the death: ___ Yes ____ No

III. CLAIM INFORMATION

Check the injury Claimant is claiming from Claimant's use of DCOCs and indicate the date(s) of occurrence:

Injury Type	Date
___ Surgery to remove gallbladder (cholecystectomy) according to medical records included in this Claim Package (Tier 1 Claim)	_____
___ Diagnosis of a gallbladder injury according to medical records included in this Claim Package, but no surgery to remove gallbladder (cholecystectomy) was performed (Tier 2 Claim)	_____

IV. CLAIM PACKAGE MATERIALS

Attach all Claim Package materials as required by Section 3.03 of the Agreement. Indicate that you have included the following in your submission:

_____ A completed copy of this Claim Form.

_____ An executed copy of the Release(s) contained in Appendix E-1 or Appendix E-2 to the Agreement.

_____ The Prescription Records specified in Section 3.03(A)(4) of the Agreement.

_____ The Medical Records specified in Section 3.03(A)(5) of the Agreement.

_____ The Event Records specified in Section 3.03(A)(6) of the Agreement, if applicable.

_____ A Stipulation of Dismissal that meets the requirements of Section 3.03(A)(8) of the Agreement.

_____ Wire instructions for use by the QSF Administrator as specified in Section 3.03(A)(9) of the Agreement.

V. CLAIMANT'S ELIGIBILITY FOR MEDICARE

A. Pursuant to the requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, codified at 42 U.S.C. 1395y(b)(7) and (b)(8), Claimant and Counsel for Claimant represent and warrant that the following information provided in this form is complete and accurate: (1) the Claimant's Social Security Number; (2) the Claimant's full legal name; and (3) the Claimant's date of birth.

B. Certification Relating to Medicare Eligibility:

To the best of her knowledge, Claimant certifies, by indicating below, that she

_____ IS eligible to receive Medicare benefits.
_____ IS NOT eligible to receive Medicare benefits.

VI. CLAIMANT'S CERTIFICATION REGARDING BANKRUPTCY

Claimant certifies, by indicating below, that she

_____ IS a party in a bankruptcy action currently pending in which she is seeking bankruptcy protection.

_____ IS NOT a party in a bankruptcy action currently pending in which she is seeking bankruptcy protection.

Dated: _____

_____
[Program Participant's Attorney Name]
[Law Firm Name]
[Address]
[City/Town, State, Zip Code]
[Area Cod/Phone Number]
[Area Code/Fax Number]
[Email address]

CERTIFICATION AND AUTHORIZATION

By submitting this Claim Form, I agree to be bound by the terms of the Agreement and the jurisdiction of the Special Master, and the court presiding over MDL No. 2100, the federal multi-district litigation venued in the United States District Court for the Southern District of Illinois (the "MDL Court"), or the state court in which the case is pending, should the MDL Court lack subject matter jurisdiction, with regard to all matters pertaining to the Agreement and the Program contained therein. I agree that the Special Master will hear motions to dismiss claims that fail to comply with the Agreement and make recommendations to the court in which my case is pending. I also agree that appeals of determinations by the Claims Administrator as to whether a Claimant is entitled to payment and, if so, the amount of that payment, will be resolved by the Special Master, and that the Special Master's decisions will be binding on the parties. I acknowledge that the Special Master's rulings on these appeals are separate from recommendations he makes as a Special Master on appointment from the MDL Court or other court. By executing this form, I acknowledge that I have been fully advised of my rights under the Agreement and elect to participate in the Program.

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Claim Form is true and correct to the best of my knowledge, information and belief.

Signature	Print Name	Date