EXHIBIT C - CATEGORIZATION AND AWARD AMOUNT FORM

Each claimant eligible for the Settlement Program must serve Exhibit C on Zimmer, **on or before May 31, 2016**.

INSTRUCTIONS

1. Complete each applicable section in order and as directed.
2. Service on Zimmer must be completed by mail to the address below or by using the Submit Your Forms button at duromsettlement.com.
   Attn: Durom Settlement Program
   Faegre Baker Daniels LLP
   110 W. Berry Street, Ste. 2400
   Fort Wayne, Indiana 46802
3. For more information, please visit www.duromsettlement.com, or contact counsel for Zimmer at info@duromsettlement.com.

CLAIMANT

1. Name	Last	First	Middle Initial
2. DOB (MM/DD/YYYY)		3. SSN	

COUNSEL

1. Represented	☐ Yes or ☐ No, skip 2 – 3		
2. Primary Attorney	Last	First	Middle Initial
3. Law Firm			

A. ELIGIBILITY

1. Is claimant a citizen or legal resident of the United States?	☐ Yes or ☐ No
2. Was claimant's Durom Cup implanted in the United States?	☐ Yes or ☐ No
3. Was claimant's Durom Cup removed less than nine years (108 months) after the date of implant?	☐ Yes or ☐ No

If claimant responded "Yes" to Questions 1, 2, <u>and</u> 3, please complete Section B.

If claimant responded "No" to Question 1, 2, <u>or</u> 3, claimant is not eligible for the Settlement Program. Please complete section A, leave the remainder of the form blank, sign the certification, and serve form as instructed above.

B. FIXED AWARD PROGRAM	
1. Was the Durom Cup removed 180 days or less after the date of implant?	☐ Yes or ☐ No
2. Is claimant deceased for reasons unrelated to the removal of the Durom Cup?	☐ Yes or ☐ No
3. Is claimant barred from filing a lawsuit by the applicable statute of limitations?	☐ Yes or ☐ No
4. Did the removal of the Durom Cup occur in connection with infection, trauma, or other causes unrelated to the Durom Cup?	☐ Yes or ☐ No
If claimant responded "No" to Questions 1, 2, 3, <u>and</u> 4, claimant may be eligible for the Base Award Program. Please complete Section C.	
If claimant responded "Yes" to Questions 1, 2, 3, <u>or</u> 4, claimant is eligible for the Fixed Award Program and is entitled to $25,000 not subject to reductions or enhancements. Please complete Section D.	

C. BASE AWARD PROGRAM	
Base Award subject to reductions and enhancements.	$175,000
1. REDUCTIONS	
1. Select the length of time the Durom Cup was implanted:	
☐ Less than five years (60 mos.)	No reduction
☐ Five years or more but less than six years (72 mos.)	- $20,000
☐ Six years or more but less than seven years (84 mos.)	-$30,000
☐ Seven years or more but less than eight years (96 mos.)	-$50,000
☐ Eight years or more but less than nine years (108 mos.)	-$75,000
2. Select claimant's age at the time the Durom Cup was implanted:	
☐ Less than seventy years	No reduction
☐ Seventy years or more but less than seventy five years	-$10,000
☐ Seventy five years or more but less than eighty	-$15,000
☐ Eighty years or more	-$30,000
3. Select each circumstance that applies:	
☐ Date of implant occurred after July 22, 2008	-$25,000
☐ Durom Cup was implanted as part of a revision surgery, defined as a surgery involving the removal of a previously implanted acetabular component	-$50,000

2. ENHANCEMENTS	
1. Bilateral eligible claimants, defined as claimants who have had two Durom Cups in opposite hips removed less than nine years after the respective date of implant are entitled to an enhancement of $25,000 or $75,000. Please see Section D.	
2. Select the number of additional revision surgeries of your hip (defined as the removal of the acetabular component) that were required after the surgery to remove the Durom Cup and that occurred within one year of the removal of the Durom Cup.	
☐ No additional revision surgery	No enhancement
☐ One additional revision surgery	+$50,000
☐ Two or more additional revision surgeries	+$100,000
3. Select the number of dislocations after removal of the Durom Cup that required medical attention and occurred within one year of the removal of the Durom Cup:	
☐ No dislocations	No enhancement
☐ One dislocation	+$5,000
☐ Two dislocations	+$10,000
☐ Three or more dislocations	+$15,000
4. Under limited circumstances, compensation for extraordinary injury or loss may be requested by completing and serving the Extraordinary Injury or Loss Claim Form (Exhibit D). If you have an extraordinary injury or loss please complete this form and Exhibit D. Exhibit D will allow you to combine your base award and extraordinary injury or award to determine your total proposed award.	
3. LIMITATIONS	
1. In no event shall a claimant's total award after application of all other reductions and enhancements exceed the amount of damages he/she is entitled to under the law. If claimant is aware of any limitation on damages that should be applied, that limitation must be applied.	

D. BILATERAL ELIGIBLE CLAIMANTS	
Bilateral eligible claimants, defined as claimants who have had two Durom Cups in opposite hips removed less than nine years after the respective date of implant, are entitled to either $25,000 or $75,000 (not subject to reductions or enhancements) for their second Durom Cup revision. To determine which additional award you are eligible for, please complete this section.	
1. Was the second Durom Cup removed 180 days or less after the date of implant?	☐ Yes or ☐ No
2. Is claimant deceased for reasons unrelated to the removal of the second Durom Cup?	☐ Yes or ☐ No
3. Is claimant barred from filing a lawsuit related to the second Durom Cup by the applicable statute of limitations?	☐ Yes or ☐ No
4. Did the removal of the second Durom Cup occur in connection with infection, trauma, or other causes unrelated to the Durom Cup?	☐ Yes or ☐ No
If claimant responded "Yes" to Questions 1, 2, 3, <u>or</u> 4	+$25,000
If claimant responded "No" to Questions 1, 2, 3, <u>and</u> 4	+$75,000

REDUCTION FOR UNREPRESENTED CLAIMANTS
If the claimant is unrepresented after all of enhancements and reductions have been applied, multiply the award amount by .71 to determine the final proposed award.

PROPOSED AWARD AMOUNT	
According to the amounts set forth above, the total amount of the Award Amount under this Settlement Agreement would be:	**$**_____
Claimant offers to accept the Award Amount stated above for a full and final settlement all past, present, and future claims that have been or could be asserted by claimant that relate to the Durom Cup, its implant, and its removal as set forth in the individual Settlement and Release Agreement (Exhibit E).	☐ Yes or ☐ No

REQUIRED SUBMISSIONS
Claimants represented by counsel must provide the following complete records, bates-labeled and in the following order. Unrepresented claimants must submit a signed HIPAA release in the form included as Attachment 1, with Section B of that release completed. ● Implant product identification ● Implant surgeon records ● Implant hospital records ● Revision surgeon records ● Revision hospital records ● Records to support any claim for an enhancement under the Base Award Program.

REQUIRED DESIGNATIONS	
Represented claimants claiming an enhancement under the Base Award Program, in Section C.2., must identify the records by bates-label that support their enhancement claims.	
Enhancement	**Bates-label**
One additional revision surgery	
Two or more additional revision surgeries	
One dislocation	
Two dislocations	
Three or more dislocations	

CERTIFICATION			
I declare under penalty of perjury under the laws of the United States of America that all of the information provided in and with this Categorization and Award Amount Form is true and correct to the best of my knowledge and belief. I acknowledge that I have read and consent to Section V(C) of the Settlement Agreement, which requires in part that I comply with Case Management Order 3: Order Establishing Common Benefit Fund entered in MDL No. 2158, and permit an assessment up to four percent (4%) to be withheld from any payment by Zimmer and paid into the Common Benefit Fund.			
Claimant's Signature		**Date**	
Printed Name			
Counsel's Signature	or ☐Unrepresented	**Date**	
Printed Name			

HIPAA COMPLIANT
AUTHORIZATION FROM INDIVIDUAL
FOR RELEASE OF MEDICAL RECORDS

Purpose: This form is used to confirm the direction of an individual that Provider use or disclose the individual's protected health information for a particular purpose.

SECTION A: Psychotherapy Notes.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

SECTION B: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Purpose: **Legal**

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization):

1. My patient file, including, but not limited to, patient history, office charts, progress notes, diagnostic test results, x-ray or laboratory reports, surgical reports, consultation reports, correspondence, drug and alcohol testing and treatment, and any other document pertaining to me.

2. Any and all records relating to my medical or psychological treatment, including, but not limited to, documents relating to office visits, hospital visits, medical or psychological tests, and any medical, psychological, or surgical treatments.

3. Any and all x-rays, MRI's, CT scans, ultrasounds or other radiological or sonographic studies.

4. My billing file, including any charges and payments for office visits, procedures, hospital visits, laboratory tests, x-rays, medication, and any other treatment for which charges were incurred.

5. You are specifically directed to discuss and provide copies of those records which may be subject to the following: a) Public Health Service Act, 42 U.S.C. §290dd 2 and the regulations thereunder at 52 Federal Regulations 21803, et seq.; b) Release of Mental Health Records to Patient and Authorized Persons; and c) Communicable Disease: Confidentiality Requirements.

6. I also authorize the physician and/or medical provider identified above to participate in ex parte interview(s) conducted by defendant's counsel so long as defendant's counsel complies with the following three conditions: (1) Provide plaintiff's counsel with reasonable notice of the time and place of the proposed interview; (2) Provide the physician and/or medical provider with a description of the anticipated scope of the interview; and (3) Communicate with "unmistakable clarity" the fact that the physician's participation in an ex parte interview is voluntary.

Entities Authorized to Use or Disclose: Name or specifically identify the persons or organizations (or the classes of persons and/or organizations), including Provider, who you are authorizing to make use of and/or to disclose the protected health information described above: This Authorization is voluntary. Pursuant to the Privacy Rules, the provider may not condition treatment, payment, or eligibility for benefits on whether the patient signs this authorization.

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing Provider to disclose and/or let use the protected health information described above:

Faegre Baker Daniels attorneys and/or their representatives

SECTION D: Expiration and Revocation.

Expiration: This authorization will expire on 08 / 1 / 2017

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Faegre Baker Daniels LLP

Telephone: 317-237-0300 Fax: 317-237-1000

Address: 300 North Meridian Street, Suite 2700, Indianapolis, IN 46204

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.

SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Provider. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.