EXHIBIT D - EXTRAORDINARY INJURY OR LOSS CLAIM FORM

Under limited circumstances detailed below, claimants may seek compensation for extraordinary injury or economic loss. To make a claim for extraordinary injury or loss, claimants must serve Exhibit D with Exhibit C on Zimmer, **on or before May 31, 2016**.

INSTRUCTIONS

1. Claimants must first complete Exhibit C.
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. EXTRAORDINARY PERSONAL INJURY

ELIGIBILITY REQUIREMENTS

1. Is claimant's extraordinary injury claim based on an injury related to removal of the Durom Cup and occurring no more than three days after discharge from hospitalization for removal of the Durom Cup?	☐ Yes or ☐ No

If claimant responded "Yes" to Question 1, select a description of the injury or injuries, provide the proposed award amount, and submit the documents listed in "Required Submissions."

☐ Pulmonary embolism

☐ Deep vein thrombosis

☐ Foot drop that persisted for at least 90 days

☐ Infection that required surgical debridement

☐ Infection that required IV antibiotics for a period of at least eight weeks

☐ Myocardial infarction or stroke

☐ Other:

Date(s) of hospitalization: (MM/DD/YYYY)	**Reason(s) for hospitalization:**

Date extraordinary injury occurred (MM/DD/YYYY)

PROPOSED AWARD AMOUNT

Claimant believes that he or she is entitled to the following amount as compensation for the extraordinary injury or injuries listed above:	$

REQUIRED SUBMISSIONS
Claimants making a claim for an extraordinary personal injury listed above must provide the following complete records, bates-labeled and in the following order: ● Treating surgeon records, defined as complete records from the surgeon(s) treating the alleged injury or injuries ● Treating hospital records, defined as complete records from the hospital(s) in which claimant was treated for the alleged injury or injuries ● A list of all medical providers seen from 10 years prior to the implant surgery to the present, including the address and dates of treatment, and a description of the treatment ● A signed HIPAA release in the form included as Attachment 1, with Section B completed.

ELIGIBILITY REQUIREMENTS	
2. Is claimant's extraordinary injury a permanent and severe disability?	☐ Yes or ☐ No
If claimant responded "Yes" to Question 2, provide a description of the disability in the space below, provide the proposed award amount, and submit the documents listed in "Required Submissions."	
Date of disability: (MM/DD/YYYY)	

Physician who determined claimant disabled:	Last	First	Middle Initial

PROPOSED AWARD AMOUNT	
Claimant believes that he or she is entitled to the following amount as compensation for the permanent and severe disability:	$

REQUIRED SUBMISSIONS
Claimants making a claim for a permanent and severe disability must provide the following complete records, bates-labeled and in the following order: ● A signed report from a physician setting out: (1) a description of the precise nature and degree of the alleged disability, including the date claimant became disabled and the expected duration of the disability, and (2) the medical basis for the belief that the alleged disability was caused by the removal of the Durom Cup ● Treating physician records, defined as complete records from the physicians treating the alleged disability; ● Treating hospital records, defined as complete records from the hospital(s) in which claimant was treated for the alleged disability ● A list of all medical providers seen from 10 years prior to the implant surgery to the present, including the address and dates of treatment, and a description of the treatment ● A signed HIPAA release in the form included as Attachment 1, with Section B completed.

B. EXTRAORDINARY LOST INCOME	
ELIGIBILITY REQUIREMENTS	
1. Was claimant employed in the 12 month period preceding removal of the Durom Cup?	☐ Yes or ☐ No
2. Did claimant's lost wages exceed 20 percent of claimant's income in the 12 months preceding the removal of the Durom Cup?	☐ Yes or ☐ No
If claimant responded "Yes" to both questions 1 <u>and</u> 2, provide the proposed award amount below, and submit the documents listed in "Required Submissions."	
PROPOSED AWARD AMOUNT	
Claimant believes that he/she is entitled to the following amount as compensation for extraordinary lost income:	$
REQUIRED SUBMISSIONS	
Claimants making a claim for extraordinary lost income claim must provide the following complete records, bates-labeled and in the following order: ● Federal tax returns, including all schedules and forms from 5 years prior to the start of the income loss to the present ● Employment records from all of claimant's employers for 5 years prior to the start of income loss to the present ● Claimants represented by counsel must also provide an economist's report setting out the basis for the lost income claim, including all documents relied on in making the report, and setting a present value for the claim. Unrepresented claimants must provide written testimony setting out the basis for the lost income claim, including all documents relied on in making the claim.	

C. TOTAL PROPOSED AWARD	
List the proposed award amount from the Categorization and Award Amount Form.	$
List the proposed award for extraordinary injury other than permanent disability.	$
List the proposed award amount for permanent and severe disability.	$
List the proposed award amount for extraordinary lost income.	$
Total all of the base amounts to determine the total proposed award amount.	$ 0
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

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 Extraordinary Injury or Loss Claim Form is true and correct.			
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.