WESTERN ASBESTOS SETTLEMENT TRUST

Instructions for Filing this Claim Form

This form may be used to file a claim with the Western Asbestos Settlement Trust, but it is not the only method for doing so. The trust provides tools for filing claims electronically and use of these tools is strongly encouraged. Please visit www.WAStrust.com for instructions on how to submit claims and supporting documents electronically.

Claim Information	
Claim Type ☐ Matrix ☐ Extraordinary ☐ Individual Review	Applicable Jurisdiction ☐ California ☐ Minnesota ☐ North Dakota
Exigency ☐ Hardship Claim	Firm Matter Number (if applicable)

Injured Party Information			
Last Name	First Name	Middle Name	Suffix
Social Security Number	Gender ☐ Male ☐ Female	Date of Birth	Date of Death (if applicable)

Is the claimant eligible for Medicare even though under age 65? Yes – No

Have any of the medical expenses of the injured party related to this claim been paid by Medicare? Yes – No

If yes, are such Medicare payments continuing? Yes-No

If so, has Medicare's lien for such payments been satisfied by claimant (such as participation in an approved Global Settlement with Medicare)? Yes – No If Yes, please submit proof of Medicare lien satisfaction.

Please list all other names by which the injured party has been known (if applicable):

Last Name	First Name	Middle Name	Suffix
Last Name	First Name	Middle Name	Suffix
Last Name	First Name	Middle Name	Suffix

If the injured party is deceased, please submit a copy of their death certificate when filing this claim form. If the injured party is not deceased, please fill out of the fields below.

Address

City	State	ZIP	Country
Phone	Email		

Representation

Please provide the following information if the claimant is represented by counsel.

If the injured party has a personal representative other than (or in addition to) his or her attorney, please submit a copy of the estate papers appointing that representative when filing this claim form.

Law Firm Name		
Mailing Address		
City	State	ZIP
Attorney Last Name	Attorney First Name	Attorney Middle Name
Phone	Fax	Email

If the claimant is represented by, or has been referred by other Counsel with a Financial Interest in this claim, also provide the following.

Law Firm Name of other Counsel with a Financial Interest in this claim		
Mailing Address		
City	State	ZIP
Attorney Last Name	Attorney First Name	Attorney Middle Name
Phone	Fax	Email

If you wish to establish a primary contact for information regarding this claim, please identify that contact below.

Contact Last Name	Contact First Name	Contact Middle Name
Phone	Fax	Email

Injury Information

Please indicate the highest disease level for which you believe this claim could be compensated, based on the required evidentiary criteria.

Disease Level

☐ Grade I Non-Malignancy ☐ Grade I Non-Malignancy Enhanced ☐ Grade I Non-Malignancy (Serious Asbestosis)

☐ Grade II Non-Malignancy ☐ Other Cancer ☐ Lung Cancer ☐ Mesothelioma

If the Disease Level selected is "Other Cancer", please indicate the disease classification:

☐ Colo-rectal ☐ Laryngeal ☐ Esophageal ☐ Kidney

☐ Non-Hodgkin's Lymphoma ☐ Chronic Lymphocytic Leukemia ☐ Other Organ Cancer

Is this claim supported by a pathological diagnosis of asbestosis?	Is this claim supported by radiographic evidence of asbestos markers?
☐ Yes ☐ No	☐ Yes ☐ No
Is this claim supported by clinical evidence of asbestosis?	Diagnosis Date
☐ Yes ☐ No	

Smoking History

Has the injured party ever smoked cigarettes?

☐ Yes ☐ No

If the answer to the preceding question is yes, please provide the following:

Number of years spent smoking:	Average packs smoked per day:	Last date known to have smoked:

Financial Dependents

Please submit documentation (e.g. interrogatory answers) which would support any claims of financial dependents when filing this claim form.

Did the injured party have a spouse or minor child as of the date litigation commenced or the proof of claim was filed, whichever is earlier?

☐ Yes ☐ No

Did the injured party have minor children, adult disabled dependent children, or dependent minor grandchildren living with them at the time of diagnosis?

☐ Yes ☐ No

Economic Loss

Please submit documentation (e.g. economic loss reports, medical expense invoices, and signed affidavits) which would support any claims of economic loss when filing this claim form.

Did the injured party incur economic loss for loss of earnings, pension, social security, and/or home services in an amount greater than the Applicable Economic Loss Threshold? (See Case Valuation Matrix) ☐ Yes ☐ No	If yes, provide the total amount for losses incurred:
Did the injured party incur medical or funeral expenses in an amount greater than the Applicable Medical Expense Threshold? (See Case Valuation Matrix) ☐ Yes ☐ No	If yes, provide the total amount for expenses incurred:

Asbestos Litigation and Claims History

If any asbestos-related lawsuits have even been filed on behalf of the injured party, please submit endorsed copies of the lawsuit face pages for each suit when filing this claim form.

Jurisdiction in which lawsuit was or could have been filed:	Date of Filing

If the injured party has ever received prior compensation from Western entities, please provide the following:

Disease Claimed	Settlement Date	Settlement Amount

Secondary Exposure

If the injured party is claiming secondary exposure, identify all occupationally exposed individuals through which the injured party was exposed to asbestos or asbestos-containing products for which the trust defendant is legally responsible. Provide work histories for all identified individuals in the subsequent section of this claim form.

If it is necessary to add additional occupationally exposed individuals, attach more copies of this page to the claim form as needed.

Occupationally Exposed Individual 1

Last Name	First Name	Middle Name	Suffix

Relationship to Injured Party	Date Exposure to this Individual Began	Date Exposure to this Individual Ended

Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the trust defendant is legally responsible:

Occupationally Exposed Individual 2

Last Name	First Name	Middle Name	Suffix

Relationship to Injured Party	Date Exposure to this Individual Began	Date Exposure to this Individual Ended

Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the trust defendant is legally responsible:

Occupational Exposure to Asbestos

List all occupation exposure to asbestos or asbestos-containing products experienced by either the injured party or an occupationally exposed individual with whom the injured party came into contact. Submit supporting documentation in conjunction with each entry provided.

Please include information for all sites at which exposure occurred as well as all sites which at which the injured party/occupationally exposed individual was employed contemporaneous to when exposure occurred. If it is necessary to add additional exposure records, attach more copies of this page to the claim form as needed.

Was the claimant exposed to asbestos products sold by or asbestos operations of Western Asbestos or Western MacArthur on or after December 5, 1980? Yes – No (Mandatory response required to determine whether claimant is covered by Medicare Secondary Payer Act)

Exposure 1

Approximate First Date at Site	Approximate Last Date at Site	Job Title/Occupation

If land-based exposure, please provide the following:

Job Site Name	City	State	Country

If exposure occurred aboard a ship at sea, please provide the following:

Name of Ship	Shipyard in which this vessel was built or repaired:

Exposure 2

Approximate First Date at Site	Approximate Last Date at Site	Job Title/Occupation

If land-based exposure, please provide the following:

Job Site Name	City	State	Country

If exposure occurred aboard a ship at sea, please provide the following:

Name of Ship	Shipyard in which this vessel was built or repaired:

Exposure 3

Approximate First Date at Site	Approximate Last Date at Site	Job Title/Occupation

If land-based exposure, please provide the following:

Job Site Name	City	State	Country

If exposure occurred aboard a ship at sea, please provide the following:

Name of Ship	Shipyard in which this vessel was built or repaired:

Declaration and Signature

All claims must be signed under penalty of perjury by the claimant, the claimant's attorney, or the personal representative (or equivalent) signing on the claimant's behalf.

I, the undersigned, have reviewed the information submitted on this claim form, and contained in all documents submitted in support of this claim, including any attached interrogatory answers or equivalent documents ("Claims Information"). I declare under penalty of perjury under the laws of the United States of America that I am informed and believe, based upon credible information available to me (including the source, context, and type of documents submitted to me in support of this claim) that the Claim Form and Claims Information (including any answers to interrogatories or equivalent documents) are true and correct.

Signature of Claimant or Claimant's Representative	Date

Print Name Here	Relationship to Injured Party

Note to Claimants and Attorneys Regarding Attorney Fee Limitations

There are fee limitations that the attorney representing the claimant must strictly abide by as stated on page 35 in Section 8.4 of the Asbestos Personal Injury Settlement Trust Distribution Procedures. At a maximum the attorney can only charge his client 25% of the payments made by the trust. This calculation is based upon the actual payments made, less any costs which are chargeable to the claimant's recovery.

To file by mail, send this completed form and all supporting documentation to:

Western Asbestos Settlement Trust
560 Hammill Lane
Reno, Nevada 89511

Western Asbestos Settlement Trust contact information:

Phone: (775) 324-5511

Web: www.wastrust.com