IN RE: PROPULSID® PRODUCTS LIABILITY LITIGATION

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

MDL NO. 1355

SECOND RESOLUTION PROGRAM

CLAIM FORM
FOR ALLEGED PERSONAL INJURY

TIER II – Non-Fatal Cardiac Arrest
or
TIER III – Primary Tachycardic Ventricular Arrhythmia

TO BE COMPLETED BY PLAINTIFF OR CLAIMANT (WITH OR WITHOUT ASSISTANCE OF COUNSEL)

I.
CATEGORY OF CLAIM:

YOU MUST CHECK OFF ONLY ONE BOX BELOW FOR THE CATEGORY OF CLAIM YOU ARE MAKING:

TIER II: NON-FATAL CARDIAC ARREST _____

OR

TIER III: PRIMARY TACHYCARDIC VENTRICULAR ARRHYTHMIA _____

II.
AGREEMENT AND INSTRUCTIONS

A. This form is to be used for submitting alleged personal injury claims by or on behalf of any Propulsid® Plaintiff in a lawsuit filed on or before November 15, 2005, (hereafter, "Plaintiff"), or by or on behalf of any Propulsid® claimant on a signed Tolling Agreement (including Plaintiffs in the Master Complaint of Louisiana Propulsid® Claimants, known as the Achord action, filed in the USDC, E. Dist. of LA) (hereafter, "Claimant") who has timely enrolled in the Propulsid® MDL 1355 Resolution Program (hereafter, the "Program") as described in the Second MDL 1355 Term Sheet dated December 15, 2005, which is incorporated herein in its entirety.

B. To properly submit this Claim Form, read the Claim Form in its entirety and answer all of the inquiries in it on the Claim Form itself [and add additional sheets if necessary] and then sign and date the Claim Form and complete a Certificate of Service of the Claim Form for Personal Injury in a form like that in the template Certificate of Service set forth in Attachment B; and:

C. It is recognized that there may be conditions which prevent you from providing all the information sought in this claim form and in providing all the required medical records. However, your vigorous diligence in providing that information and in providing those records is required. The Medical Review Panel has the discretion to approve or deny your claim based on the information that you submit.

D. (a) Serve the **originals** of:

(i) the completed, signed and dated Claim Form; and

(ii) the completed, signed and dated Attachments B, C and D, being sure that in Attachment B (the Certificate of Service of Claim Form for Personal Injury), you check off the manner of service.

(b) the **originals** of these executed documents should be served on:

Special Master's Office
In re: Propulsid MDL 1355 Resolution Program
400 Poydras Street, Suite 2820
New Orleans, LA 70130
Telephone: (504) 586-7995

E.. You must submit this Claim Form and serve it in the manner described below within 120 days of service of notice by Plaintiffs' Steering Committee ("PSC") that the Program's minimum enrollment levels have been reached, or 120 days after serving your Enrollment Form, whichever is later.

F. You will have 60 days after service of your Claim Form to serve the medical records satisfying the 'medical records requirements' set forth in Section 2 of Exhibit A to the Term Sheet (unless pursuant to Section 7 of the Term Sheet, upon application to the Special Master, you have demonstrated a good faith effort to secure the medical records, then the period for securing records shall be extended for an additional 60 days. (see Attachment A to this Claim Form for a description of the 'medical records requirements' contained in Section 2 of Exhibit A to the Term Sheet.)

G. If you fail to submit the medical records required to process your claim within 60 days after you serve your Claim Form, then subject to the exception in Section 7 of the Term Sheet allowing for an additional 60 days to secure records upon a showing of good faith effort to secure the records (made by application to the Special Master), your claim shall be dismissed with prejudice in its entirety. No further action is to be taken on it and no litigation may be commenced or maintained to attempt to pursue that or any other Propulsid®-related claim.

H. If your claim is a Tier II claim for personal injury based on an alleged non-fatal cardiac arrest (see Exhibit A to Term Sheet, Section 2, 'Settlement Categories' – Tiers I and II), then within 60 days of service of your medical records (and no later than 120 days from service of your Claim Form), you may also serve on the medical panel a confidential memorandum explaining your contentions as to your qualification under the program and the category (Tier II – level A or B) under which you have submitted your claim. (see Section 13 of the Term Sheet.) Pursuant to Section 13 of the Term Sheet, the memorandum is not to exceed five pages. Exhibits to the memorandum may be abstracts or full documents not to exceed thirty pages. No expert reports or affidavits shall be submitted.

I. With respect to all personal injury claims in which you are entitled to an award under this Program, before payment of such award shall be made, you must provide Lead Counsel for Defendant with the full names, relationship to the alleged personal injury Propulsid® user, dates of birth and Social Security numbers of all persons entitled under applicable state law to make a claim (including but not limited to loss of consortium claims) or share in settlement proceeds resulting from the alleged Propulsid® user's ingestion of Propulsid®. Moreover, all such persons must comply with all provisions of the Term Sheet; and

J. You agree to obtain court approval of any settlement awarded under this Program, if such court approval is required under applicable state law; and

K. You agree to take all steps necessary for the court appointment of any persons required to represent minor or incompetent statutory heirs with respect to any claims submitted under this Program and any settlements awarded; and

L. If you are required to pursue any court proceedings with respect to finalizing any settlement under this Program, you agree that all such court proceedings must be maintained in the strictest confidence and that all court papers shall be filed

under seal and all hearings held in private to the extent allowable under applicable state law and procedure. You also agree that drafts of all such court papers must be approved by Lead Counsel for Defendants before filing with the court and may in no event disclose the amount of any settlement award.

M. You also acknowledge that pursuant to Section 20 of the Second MDL Term Sheet, upon submitting the requisite Claim Form, you must state whether or not you have reached a settlement with an entity other than the Janssen and Johnson & Johnson defendants. You also agree that if it is determined that you are eligible for an award payment, you must inform the Special Master exclusively of the amount of any such settlement.

N. By having enrolled in this Program, you acknowledged that the decisions of the Medical Panel and Special Master may be ones with which you disagree, but further acknowledge that this eventuality is part of the Program, and you accepted that eventuality by having authorized your attorney to enroll you in the Program. You further specifically agree that the decisions of the Medical Panel and Special Master are final and not appealable.

O. It is acknowledged that, having enrolled in this Program, you thereby surrendered your rights to litigate your case and any other claims and potential claims relating in any way to Propulsid®, including but not limited to all claims, liabilities, demands, actions, suits and causes of actions for damages (including but not limited to current and future causes of action for wrongful death, and current and future causes of action for personal injury and loss of consortium), restitution, disgorgement, unjust enrichment, civil penalties, statutory penalties, injunctive and/or declaratory relief, whether class, individual, representative or otherwise in nature, including costs, expenses, penalties, and attorneys' fees, known or unknown, suspected or unsuspected, in law or equity, that accrued prior to the date of enrolling in the Program that you ever had, now have or hereafter can, shall or may have, which has been asserted or could have been asserted in the MDL or in any other action and you acknowledge that having enrolled in the Second Program, you unconditionally, fully and forever released whatever rights you, your heirs, beneficiaries and representatives may have had, or may ever have against defendants Johnson & Johnson, Janssen, L.P., Janssen Pharmaceutica Inc. and Janssen Pharmaceutica, N.V., all health care professionals, health care providers, health care facilities, pharmacies and other distributors of Propulsid®, and their parents and subsidiaries, affiliates, agents, attorneys, servants, employees, officers and directors and those who may have acted in concert with them, together with their respective insurers, relating to your alleged ingestion of Propulsid®. You also acknowledge that when you enrolled in the Program, you were authorized to release the aforementioned claims on behalf of yourself and your heirs, beneficiaries and representatives and that you also waived California Civil Code Section 1542, if applicable, which provides that, "a general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor." You also acknowledge that if the Medical Panel determines that you are entitled to an award under this Program, you must

comply with all of the provisions of the Term Sheet prior to payment of such award, including but not limited to preparing any documentation called for under the Term Sheet for finalizing payment.

Attorneys for Claimants and/or Plaintiffs shall provide a completed W-9 Form, a copy of which is attached hereto as Attachment D, which form shall provide, among other things, the appropriate tax identification number for that attorney.

P. The signatories to the Claim Form, the law firms with which they are affiliated and the Plaintiffs and Claimants identified on Attachment A specifically agree to maintain the confidentiality of any awards of compensation that might result from this Program.

Q. You agree to execute and serve with this Claim Form the original Authorization to Release Medical Records attached hereto as Attachment C.

III.
CLAIM FORM FOR PERSONAL INJURY (Tiers II and III)

A. ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, AS NECESSARY, ATTACH ADDITIONAL SHEETS:

1. Information re: Alleged Propulsid® User:

a. Current name and other names (e.g., maiden names, married names) used by the alleged Propulsid® user for the ten years prior to the alleged Propulsid® user's alleged adverse event through 60 days prior to service of this Claim Form (last name first, followed by first name and middle initial):

_____

b. Alleged Propulsid® User's Current Residence Address:

_____

_____

_____

c. Alleged Propulsid® User's DOB: _____

e. Alleged Propulsid® User's SSN: _____

2. Information for all Plaintiffs/Claimants Submitting this Claim re: the above-listed alleged Propulsid® user if other than the alleged Propulsid® user [attach

separate sheet(s) as necessary to answer all of the following questions re: each such Plaintiff/Claimant]:

a. Current name and other names used by each Plaintiff/Claimant at the time of and subsequent to Plaintiff's filing of a Propulsid® lawsuit re: the alleged Propulsid® user's alleged ingestion of Propulsid® or at the time of or subsequent to Claimant entering into a Tolling Agreement or joining the Achord action with respect to the alleged Propulsid® user's alleged ingestion of Propulsid® (last name first, followed by first name and middle initial):

_____

b. Plaintiff's/Claimant's Current Residence Address:

_____

_____

_____

c. DOB: _____

d. SSN: _____

e. Relationship to Alleged Propulsid®User: _____

f. Details re: Plaintiff's/Claimant's relationship to alleged Propulsid® user (e.g., whether Plaintiff/Claimant is the representative of an alleged Propulsid® user who was/is a minor, etc.): _____. If Plaintiff/Claimant is a court-appointed representative, please attach copies of the court orders making such appointment.

3. Alleged Propulsid® User's Alleged Ingestion of Propulsid®:

a. Date(s) ingested: _____

b. Dosage(s) ingested (amount (e.g., 20mg.) and number daily):
_____/_____

c. Ordering Physician(s) Name(s), Addresses and Phone Numbers:

_____

d. Pharmacies where all Propulsid® Prescriptions were ever filled (names, addresses and phone numbers of all such pharmacies):
_____

_____

_____

4. Other Medications Used by Alleged Propulsid® User:

a. For each prescription medication ingested by the alleged Propulsid® user during the three years prior to the alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

b. For each over-the-counter medication ("OTC") ingested by the alleged Propulsid® user during the three months prior to the alleged adverse event, provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

5. Alleged Adverse Event:

a. Date of Alleged Adverse Event:

_____

b. Description of Nature of Alleged Adverse Event:

_____

c. Names, Addresses, Telephone Numbers of Physician(s), Physician's Assistants and Nurse Practitioners who treated the alleged Propulsid® user for the alleged injuries or adverse event he or she suffered that are being attributed to the alleged ingestion of Propulsid® and the dates of such treatment from the date of the alleged adverse event through 60 days before service of this Claim Form. (Include names, addresses and phone numbers of any pertinent treatment facilities, including but not limited to hospitals, ambulance or paramedic companies and fire department rescue crews.)

_____

_____

_____

6. Medical Treatment History:

a. For all medical treatment, of any kind, received by the alleged user in the one year prior to the alleged adverse event through 60 days before service of this Claim Form (or if the alleged Propulsid® user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) from any type of medical practitioner (doctors, physician's assistants, nurse practitioners, therapists, hospitals, clinics, pharmacies, ambulance services, paramedic companies and home health services) provide for each:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

b. For each of the alleged Propulsid® user's emergency room visits and hospitalizations during the three years preceding the alleged adverse event through 60 days before service of this Claim Form (or if the alleged Propulsid® user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days prior to submission of this Claim Form), provide the following:

(i) facility name;

(ii) facility address;

(iii) condition leading to hospitalization;

(iv) dates of admission; and

(v) duration of hospitalization.

c. For all of the following cardiac studies ***excluding* ECGs** (see 6.e. below re ECGs) performed during the three years before the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) ***including*** holter monitoring, stress tests, heart scans, echo-cardiograms, cardiac angiography/catheterization, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

d. For the three years prior to the alleged Propulsid® user's alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) for all treatment received by the alleged user from the alleged user's primary care physician(s), cardiologist(s), gastroenterologist(s) and/or pediatrician(s), provide:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

e. For the ten years prior to the alleged Propulsid® user's alleged adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form) for each **ECG**, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

f. For the ten years prior to the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide the following for all hospital records where cardiac concerns were implicated. Cardiac concerns include but are not limited to chest pain or angina, syncope (fainting or near fainting), heart attack, congestive heart failure, hypertension, cardiomyopathy, valvular disease, infections of the heart or heart valve and myocarditis.

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

g. For the ten years prior to the alleged Propulsid® user's adverse event through 60 days before service of this Claim Form (or if the alleged user was under age 12 at the time of the alleged adverse event, during the alleged user's entire life through 60 days before service of this Claim Form), provide the following for all hospital records where GI concerns were implicated:

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

h. For each insurance or other company that provided medical bill coverage for the alleged Propulsid® user's health care for treatment of the alleged Propulsid-related adverse event and injuries allegedly resulting from said alleged adverse event from the date of the alleged adverse event through 60 days before service of this Claim Form, provide:

(i) company name of insurer;

(ii) address and telephone number; and

(iii) dates of coverage.

i. If any of the alleged Propulsid® user's medical expenses relating to his/her alleged ingestion of Propulsid® were covered by Medicare, Medicaid or military benefits, i.e., V.A. or Tri-Star, so state, and describe any medical liens of which you are aware:

_____

7. **Economic Losses:**

List all economic losses you are claiming, including but not limited to lost wages, and in the event you are claiming economic loss in the form of lost wages, provide the name and address of the alleged Propulsid® user's employer, the alleged user's title at his or her place of employment and the dates of employment you claim were lost due to Propulsid® use:

_____

_____

_____

8. Propulsid®-Related Settlements With Other Third Parties:

a. State whether you have reached a settlement with any other party besides one of the Janssen or Johnson & Johnson defendants, e.g., including but not limited to with a doctor, hospital, pharmacy, or insurer:

_____

b. If you answered "yes" to question III.8.a. above, identify the name of the person and/or entity with whom the settlement was reached:

9. Pendency of Propulsid® Lawsuits and/or Claims:

a. State whether you are involved in any pending Propulsid®-related lawsuit or claim other than the one for which you are submitting this Personal Injury Claim Form:

_____

b. If you answered "yes" to question III.9.a. above, describe the name of, venue of, docket number (if a filed lawsuit) and parties to the lawsuit(s) and/or claim(s):

_____

_____

_____

B. COMPLETE, SIGN AND DATE CERTIFICATE OF SERVICE OF CLAIM FORM FOR PERSONAL INJURY (TIER II or TIER III) CLAIM IN THE FORM CONTAINED IN THE TEMPLATE CERTIFICATE OF SERVICE IN ATTACHMENT B.

C. SIGN AND DATE BELOW.

Dated: _____ [Plaintiff's/Claimant's Signature]
Printed Name of Plaintiff/Claimant
Printed Residence Address

Dated: _____ [Signature of Plaintiff's/Claimant's Attorney
Printed Individual Attorney Name
Law Firm Name, Address, Telephone/Fax