

**Claim Form & Declaration - Attorney
J T Thorpe Company Successor Trust**

1.4 Special Claims Status

If you believe your claim qualifies as an Extraordinary Claim and/or Exigent Hardship Claim (**see Attorney Instructions for Filing a Claim With the J T Thorpe Company Successor Trust for the definition of an Extraordinary Claim and Exigent Hardship Claim**), check the appropriate box(es) indicating this.

- Extraordinary Claim
- Exigent Hardship Claim

Part 2: DIAGNOSED DISEASES

DISEASE CLAIMED

Check only the box indicating the highest Disease Level claimed by the Injured Party for which there is attached medical evidence to support the claim. Provide the date of diagnosis for the disease claimed. **See Attorney Instructions for Filing a Claim With the J T Thorpe Company Successor Trust for the applicable medical evidence required for each disease.**

Disease Level I

Date of Diagnosis

- Asbestosis _____/_____/_____
- Pleural Disease _____/_____/_____

Disease Level II

- Asbestosis _____/_____/_____
- Pleural Disease _____/_____/_____

Disease Level III

- Severe Asbestosis _____/_____/_____

Disease Level IV Other Cancer

- Colorectal Cancer _____/_____/_____
- Esophageal Cancer _____/_____/_____
- Laryngeal Cancer _____/_____/_____
- Pharyngeal Cancer _____/_____/_____
- Stomach Cancer _____/_____/_____

INJURED PARTY: _____ **SSN:** _____

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3.7 Was a Proof of Claim filed in the J T Thorpe Chapter 11 Bankruptcy Case? Yes No

If Yes, provide a copy of the Proof of Claim.

Part 4: OCCUPATIONAL EXPOSURE

Part 4 of this Claim Form must be completed if the Injured Party claims that his/her asbestos-related disease is a direct result of his/her occupational asbestos exposure, as opposed to Derivative Exposure (exposure through some other person). If the Injured Party claims Derivative Exposure, that is, the Injured Party claims his/her asbestos-related disease is a direct result of his/her asbestos exposure through another person, complete Part 5: DERIVATIVE EXPOSURE: EXPOSURE THROUGH AN OCCUPATIONALLY EXPOSED PERSON. **See Attorney Instructions for Filing a Claim With the J T Thorpe Company Successor Trust for the exposure evidence necessary to meet the requirements for a valid and compensable claim.**

Exposure Period *[For each additional exposure period, please copy this page and attach the completed information.]*

4.1 J T Thorpe Asbestos Exposure

Date J T Thorpe Exposure Began: ____/____/____ Date J T Thorpe Exposure Ended: ____/____/____

Employer: _____ City: _____ State: _____

Jobsite: _____ City/Location: _____ State: _____

Occupation: _____

4.2 Five (5) Year Cumulative Occupational Exposure *[Please check all applicable statements.]*

- Handled raw asbestos fibers on a regular basis;
- Fabricated asbestos-containing products so that the Injured Party in the fabrication process was exposed on a regular basis to raw asbestos fibers;
- Altered, repaired or otherwise worked with an asbestos-containing product such that the Injured Party was exposed on a regular basis to asbestos fibers; or
- Was employed in an industry and occupation such that the Injured Party worked on a regular basis in close proximity to workers engaged in the activities of handling, fabricating, altering, or repairing asbestos or asbestos-containing products.

4.3 Other Asbestos Exposure *[Complete the following information for the Injured Party's first exposure to any asbestos product, not just J T Thorpe asbestos exposure.]*

Date Asbestos Exposure Began: ____/____/____ Date Asbestos Exposure Ended: ____/____/____

Employer: _____ City: _____ State: _____

Jobsite: _____ City/Location: _____ State: _____

Occupation: _____

INJURED PARTY: _____ **SSN:** _____

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5.4 OEP's Other Asbestos Exposure: [Complete the following information for the OEP's first exposure to any asbestos product, not just JT Thorpe asbestos exposure.]

Date Asbestos Exposure Began: ____/____/____ Date Asbestos Exposure Ended: ____/____/____

Employer: _____ City: _____ State: _____

Jobsite: _____ City/Location: _____ State: _____

Occupation: _____

Part 6: PROOF OF EXPOSURE

Proof of Exposure is demonstrated by one or more of the following: (Check the appropriate box or boxes)

The Injured Party or the Claimant Representative may demonstrate Proof of Exposure by completing **Part 7: DECLARATION** of this claim form, allowing the claim form to serve as the declaration.

Claim Form as Declaration

OR

One or more of the following documents may be submitted as Proof of Exposure. The documents must be submitted as an attachment to the Claim Form and **Part 8: CERTIFICATION** section of this claim form must be completed. Check the boxes below for the documents that are submitted as an attachment to this Claim Form.

- Separate Injured Party or Official Representative Affidavit
- Co-worker Affidavit
- Invoices, employment, construction or similar records
- Verified Listing of employer/jobsites
- Verified Work History
- Answers to Interrogatories with verification page. Specify pertinent page number(s) ____.
- Deposition Transcript with cover page(s). Specify pertinent page number(s) ____.

INJURED PARTY: _____ **SSN:** _____

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Part 7: DECLARATION

If Part 7: DECLARATION is not completed, Part 8: CERTIFICATION must be completed.

I _____ ("DECLARANT") declare under penalty of perjury under the
[PRINTED NAME OF DECLARANT]

laws of the United States of America that all of the information set out in this declaration (Parts 1-5) is true and correct..

Executed this ___ day of _____, 20___, at _____, _____.
[City] [State]

[SIGNATURE OF DECLARANT]

Part 8: CERTIFICATION

If Part 8: CERTIFICATION is not completed, Part 7: DECLARATION must be completed.

This claim is certified by (check one)

- The Injured Party
- The individual acting in an official capacity on behalf of the Injured Party (the "Claimant Representative")

I have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge, under penalty of perjury, the information submitted is accurate and complete.

Signature of Injured Party or Claimant Representative

Printed name

- Attorney acting as Attorney-in-Fact

The undersigned certifies, under the penalty of perjury, as follows: I am authorized to file this Claim Form; I, or other trained personnel within my firm, have reviewed the information submitted on this Claim Form and all documents submitted in support of this claim; and to the best of my knowledge, based on policies and procedures adopted and implemented by my firm concerning claims processing, the information submitted is true, accurate and complete, and/or other information is included within the claimant's file and is derived from information provided by the claimant, one or more of the claimant's co-workers or the claimant's medical experts.

Signature of Attorney acting as Attorney-in-Fact

Printed name

INJURED PARTY: _____ **SSN:** _____

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Part 9: ATTORNEY CERTIFICATION

This section is for Legal Counsel only and must be completed only if (i) Part 7 is signed by the Claimant Representative and Official Capacity documents are not provided or (ii) Part 8 is signed by the Claimant Representative or the Attorney and Official Capacity documents are not provided.

Attorney certifies that this claim is filed on behalf of the Claimant Representative acting for the Injured Party and that the Claimant Representative has official capacity to file this claim based on the operation of law.

Signature of Attorney representing the Claimant Representative

Printed name

INJURED PARTY: _____ **SSN:** _____