ASARCO Asbestos Personal Injury Settlement Trust

– Claim Form for Unliquidated Asbestos Personal Injury Claims –

General Instructions for filing this Claim Form:

This Claim Form for Unliquidated Asbestos Personal Injury Claims should be completed only by holders of unliquidated Asbestos Personal Injury Claims seeking to liquidate their claim under the Expedited Review or Individual Review processes of the ASARCO Asbestos Personal Injury Settlement Trust (the "Trust"). See Section 5.3(a) and (b) of the ASARCO LLC Asbestos Personal Injury Settlement Trust Distribution Procedures (the "TDP") for further information regarding the Expedited and Individual Review processes.[1] Please see the preamble to the TDP for the definition of "ASARCO" as used herein.

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; ***submitting an incomplete form may result in delays in processing and/or the Trust not being able to assign the claim a position in the first-in-first-out (FIFO) processing queue***. Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the review election which best suits the injured party's situation:

☐ Expedited ☐ Individual ☐ Extraordinary ☐ Secondary Exposure ☐ Foreign ☐ Asbestos Premises Liability Claim

If requesting exigent treatment, check here: ☐ Exigent Health ☐ Exigent Hardship

Law Firm's matter number for this claim: _____

Section 1: Injured Party Information				
Last Name	First Name		Middle Name	Suffix
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Date of Death (mm/dd/yyyy) (if applicable)	Was death asbestos related? ☐ Yes ☐ No
Mailing Address (if not represented by counsel)				
City	State	Zip	Daytime Telephone	

Section 2: Law Firm / Attorney Information			
If represented by counsel, please provide the following information.			
Law Firm Name			Filer ID
Mailing Address			
City		State	Zip Code
Attorney Last Name	Attorney First Name	Attorney Middle Name	Attorney Suffix
Direct Telephone	Facsimile	E-mail Address	

[1] Capitalized terms used herein and not otherwise defined shall have the meanings assigned to them in the TDP.

Section 3: Asbestos Related Injury

Check the box next to the highest disease level the injured party is claiming.

Disease Level

☐ Other Asbestos Disease (Level I) ☐ Nonmalignant Asbestos Disease (Level II) ☐ Nonmalignant Asbestos Disease (Level III)

☐ Severe Asbestosis (Level IV) ☐ Other Cancer (Level V) ☐ Lung Cancer 2 (Level VI)

☐ Lung Cancer 1 (Level VII) ☐ Mesothelioma (Level VIII)

Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level V), please specify malignancy

Section 4: Smoking History *(required only for Individual Review Claims for Lung Cancer 1 (Level VII) and Lung Cancer 2 (Level VI))*

In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of said products smoked per day.

Product	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
☐ Cigarettes ☐ Cigars ☐ Pipes			
☐ Cigarettes ☐ Cigars ☐ Pipes			
☐ Cigarettes ☐ Cigars ☐ Pipes			

Section 5: Personal Representative *(if applicable)*

Last Name	First Name	Middle Name	Suffix

Social Security Number (optional)	Capacity of Personal Representative ***(i.e. Administrator, Executor, Guardian, etc.)***

Mailing Address			
City	State	Zip	Daytime Telephone

Section 6: Asbestos Litigation and Claims History

If an asbestos-related lawsuit has ever been filed on behalf of the injured party, please provide the following information.

Filing Date (mm/dd/yyyy)	State	Court	Docket Number

ASARCO named as defendant? ☐ Yes ☐ No	Has the injured party ever received settlement monies related to this lawsuit from ASARCO or its insurers? ☐ Yes ☐ No	If "yes", amount: $_____

Jurisdiction Selection

If no lawsuit has ever been filed against ASARCO on behalf of the injured party, indicate the state elected as the Claimant's Jurisdiction: _____

Jurisdiction elected is (please check one of the following):

☐ The state in which the injured party resided at the time of diagnosis.
☐ The state in which the injured party resides when this claim is filed with the Trust.
☐ A state in which the injured party experienced exposure to an asbestos-containing product or to conduct for which ASARCO has legal responsibility.

Has a claim on behalf of the injured party ever been submitted to ASARCO pursuant to an administrative settlement agreement? ☐ Yes ☐ No

If Yes, provide the date of such submission (mm/dd/yyyy): _____

Was the injured party or claimant a party to a tolling agreement with ASARCO? ☐ Yes ☐ No If Yes, provide the beginning and ending dates, if any, of the tolling and attach documentation of the agreement.

Beginning date (mm/dd/yyyy): _____ Ending date (mm/dd/yyyy): _____

Section 7: Occupational Exposure to Asbestos Products

Provide information below for each location at which the injured party alleges exposure to any products or materials containing asbestos that were mined, manufactured, sold, supplied, produced, specified, selected, distributed or in any way marketed by ASARCO, for which ASARCO has legal responsibility. If the duration of the injured party's ASARCO Exposure is not sufficient to meet the other exposure criteria (Significant Occupational Exposure or cumulative occupational exposure as required for the Disease Level in question), please provide information regarding other asbestos exposure to satisfy the applicable exposure criteria. List each site, industry, and occupation combination separately. Provide the complete name and location of each individual site. Attach additional copies of this page if more space is required.

Part 1

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation		
Site of Exposure (plant or site name)		City	State	Country
Industry in which exposure occurred				
Names of all asbestos-containing products or materials to which injured party was exposed and for which injured party alleges ASARCO is legally responsible.				

Description of Significant Occupation Exposure at this jobsite (check all that apply)

☐ Injured party handled raw asbestos fibers on a regular basis.

☐ Injured party fabricated asbestos-containing products so that the injured party in the fabrication process was exposed on a regular basis to raw asbestos fibers.

☐ Injured party altered, repaired, or otherwise worked with an asbestos-containing product such that the injured party was exposed on a regular basis to asbestos fibers.

☐ Injured party was employed in an industry and occupation such that the injured party worked on a regular basis in close proximity to workers engaged in one or more of the above three activities.

☐ Other (please describe in as much detail as possible):

Part 2

If the injured party is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claim satisfies Section 5.4(a) of the ASARCO LLC Asbestos Personal Injury Settlement Trust Distribution Procedures:

Section 8: Secondary Exposure *(not required for Expedited Review)*

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person (OEP), complete Section 7, Part 1 with the exposure information for the OEP and provide the information below.

Date Exposure to OEP Began (mm/dd/yyyy)	Date Exposure to OEP Ended (mm/dd/yyyy)	Relationship to OEP

Description of how injured party was exposed through the OEP to asbestos mined by ASARCO, to products manufactured, produced or distributed by ASARCO, or to conduct that exposed the injured party to asbestos or an asbestos-containing product, for which ASARCO has legal responsibility.

Section 9: Employment / Earnings Information *(required only for claims for lost wages or Exigent Hardship Claims based on lost wages)*

If economic losses are being claimed, please enclose an economic loss report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)

☐ Full-time	☐ Part-time	☐ Retired
☐ Partially Disabled	☐ Fully Disabled	☐ N/A (deceased)

Amount of last annual wages	Date of last wages received (mm/dd/yyyy)

Section 10: Dependents *(not required for Expedited Review)*

List injured party's spouse and/or any other dependents.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No

Section 11: Certification and Signature

This claim form must be signed by an attorney or, if the injured party is not represented by an attorney, the injured party or the injured party's personal representative.

Upon information and belief, formed after an inquiry reasonable under the circumstances, I hereby certify, under penalty of perjury, that the information submitted is accurate.

Signature of Injured Party, Personal Representative, or Attorney	Date Signed (mm/dd/yyyy)

Print Name Here

Signatory's Relationship to Injured Party

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

ASARCO Asbestos Personal Injury Settlement Trust
c/o Verus Claims Services, LLC
3967, Princeton Pike
Princeton, NJ 08540

Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form.

For all claimants:

☐ Medical records supporting the diagnosis of the claimed Disease Level (see filing instructions for requirements).

☐ Proof of ASARCO Exposure, as set forth in the filing instructions and required by the TDP.

For deceased injured parties:

☐ Death certificate.

For claims for lost wages or Exigent Hardship Claims based upon lost wages:

☐ Documentation supporting the claim that any and all wage loss incurred by the injured party was the result of the injured party's asbestos-related disease. This documentation would include, but not be limited to, medical records and/or reports, reports from governmental or insurance agencies and/or reports from the injured party's most recent employer.

☐ Tax returns and/or W-2 forms for the last three (3) full years of employment.

For Exigent Health Claims for Disease Levels IV-VII:

☐ Declaration or affidavit by a physician who has examined the claimant as required by the TDP.

Other supporting documentation, as applicable:

☐ Letters of Administration or other proof of the personal representative's official capacity, if applicable pursuant to state law.

☐ Copy of tolling agreement (if applicable under Section 6).

If you are filing an Individual Review claim and have additional information (see TDP section 5.3(b)(2)) you would like the Trust to consider in evaluating your claim, please include any related documents or information with the Claim Form.