

United Gilsonite Laboratories Asbestos Personal Injury Trust

– Claim Form for Unliquidated Asbestos Personal Injury Claims –

General Instructions for filing this Claim Form:

This Claim Form should be completed only by holders of Unliquidated Asbestos Personal Injury Claims seeking to liquidate their claim under the United Gilsonite Laboratories Asbestos Personal Injury Trust’s (the “Trust”) Expedited Review or Individual Review processes as set forth in Section 5.2(a) or (b) of the United Gilsonite Laboratories Asbestos Personal Injury Trust Distribution Procedures (as may be amended from time to time, the “TDP”).¹ As used herein, “UGL” or “Debtor” shall mean and refer to United Gilsonite Laboratories.

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

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Death (mm/dd/yyyy) (if applicable)	Was death asbestos related? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mailing Address (if not represented by counsel)				
City	State	Zip	Daytime Telephone	

Section 2: Law Firm / Attorney Information
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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	
<input type="checkbox"/> Other Asbestos Disease (Level I)	<input type="checkbox"/> Asbestosis/Pleural Disease (Level II)
<input type="checkbox"/> Severe Asbestosis (Level IV)	<input type="checkbox"/> Other Cancer (Level V)
<input type="checkbox"/> Lung Cancer 1 (Level VII)	<input type="checkbox"/> Mesothelioma (Level VIII)
<input type="checkbox"/> Asbestosis/Pleural Disease (Level III)	<input type="checkbox"/> Lung Cancer 2 (Level VI)
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.

<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipes	<input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipes	<input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipes	<input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day

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

Part 1:

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
UGL named as defendant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the injured party ever received settlement monies related to this lawsuit from UGL or its insurers? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", amount: \$ _____	

Part 2:

Provide the following information regarding the Claimant's Jurisdiction; prior settlements and tolling agreements.

Has the injured party or the injured party's representative, on behalf of the injured party, executed a release releasing UGL? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach a copy of the release.
Jurisdiction Selection If no lawsuit has ever been filed against UGL on behalf of the injured party, indicate the state elected as the Claimant's Jurisdiction: _____
Jurisdiction elected is (please check one of the following): <input type="checkbox"/> The state in which the injured party resided at the time of diagnosis. <input type="checkbox"/> The state in which the injured party resides when this claim is filed with the Trust. <input type="checkbox"/> A state in which the injured party experienced exposure to an asbestos-containing product or to conduct for which UGL has legal responsibility. <input type="checkbox"/> Pennsylvania, because all jurisdictions which could otherwise be elected describe the claim as one for "exemplary" or "punitive" damages.
Has a claim on behalf of the injured party ever been submitted to UGL pursuant to an administrative settlement agreement? <input type="checkbox"/> Yes <input type="checkbox"/> 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 UGL? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the beginning and end dates, if any, of the tolling and attach documentation of the agreement. Beginning Date (mm/dd/yyyy): _____ Ending Date: (mm/dd/yyyy): _____

Section 7: Exposure to Asbestos Products

Provide the information requested in Part 1 and Part 2 below, as applicable. Part 3 must be completed. Part 4 must be completed if you are filing an Extraordinary Claim and Part 5 must be completed if you are filing a Foreign Claim.

Part 1: Do-it-Yourself Exposure to Asbestos Products

Provide information below for each location at which the injured party alleges exposure through a Do-it-Yourself project (a) to an asbestos-containing product sold, distributed, marketed, handled, processed, or manufactured by UGL or for which it otherwise has legal responsibility or (b) to conduct for which UGL has legal responsibility that exposed the claimant to an asbestos-containing product. List each project separately. Attach additional copies of this page if more space is required.

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Location of Do-it-Yourself project: City	State	Country
Describe Do-it-Yourself Project.				
Location where Do-it-Yourself product was purchased: City		State	Country	
Names of all asbestos-containing products or materials to which injured party was exposed during the Do-it-Yourself project and for which injured party alleges UGL is legally responsible.				
If this is a claim for secondary exposure, please enter the name of the person performing the Do-it-Yourself project and complete Section 8: Name: _____				

Part 2: Occupational Exposure to Asbestos Products

Provide information below for each location at which the injured party alleges exposure (a) to an asbestos-containing product sold, distributed, marketed, handled, processed, or manufactured by UGL or for which it otherwise has legal responsibility or (b) to conduct for which UGL has legal responsibility that exposed the claimant to an asbestos-containing product. If the duration of the injured party's Debtor 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.

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 UGL 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 such 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.

If this is a claim for secondary exposure, please enter the name of the occupationally exposed person and complete Section 8:

Name: _____

Part 3: Medicare Reporting

For Medicare reporting purposes, provide the end date of the injured party's exposure to asbestos-containing products and/or conduct for which the injured party alleges UGL has legal responsibility (mm/dd/yyyy): _____

Part 4:

If the injured party is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claim satisfies Section 5.3(a) of the TDP:

Part 5:

Does the claimant allege that the injured party's exposure to an asbestos-containing product or conduct for which UGL has legal responsibility occurred outside of the United States and its Territories and Possessions and outside the Provinces and Territories of Canada?

___ Yes ___ No

If the response to the previous question was yes, provide the following information about the foreign jurisdiction(s) in which the exposure allegedly occurred (attach additional copies as necessary):

Name of the Country: _____

Name of the County, Province, and/or City: _____

Describe how the alleged exposure occurred within the foreign jurisdiction: _____

The Trust may require additional information regarding your Foreign Claim and shall take into account all relevant procedural substantive legal rules to which the claim would be subject in the Claimant's Jurisdiction, as defined in Section 5.2(b)(2) of the TDP.

Section 8: Secondary Exposure (if applicable)

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person (OEP), or Do-it-Yourself person (DIYP), complete Section 7 Parts 1 and 2, as applicable, with the exposure information for the OEP and/or DIYP and provide the information below. Attach additional copies of this page if necessary.

Date Exposure to OEP or DIYP Began (mm/dd/yyyy)	Date Exposure to OEP or DIYP Ended (mm/dd/yyyy)	Relationship to OEP or DIYP
Description of how injured party was exposed through the OEP or DIYP to asbestos-containing products sold, distributed, marketed, handled, processed, or manufactured by UGL, or to conduct for which UGL has legal responsibility that exposed the claimant to asbestos-containing products.		

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) <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Partially Disabled <input type="checkbox"/> Fully Disabled <input type="checkbox"/> N/A (deceased)		Amount of last annual wages	Date of last wages received (mm/dd/yyyy)
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> 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)
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Print Name Here

Signatory's Relationship to Injured Party

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

United Gilsonite Laboratories Asbestos Personal Injury Trust
 c/o Claims Processing Facility, Inc.
 East-West Corporate Center
 1771 West Diehl Road, Suite 220
 Naperville, Illinois 60563

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 Debtor 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 release of UGL (if applicable under Section 6, Part 2).
- Copy of tolling agreement (if applicable under Section 6, Part 2).

If you are filing an Individual Review claim and have additional information (see TDP section 5.2(b)(2)) you would like the Trust to consider in evaluating your claim, please include any related documents or information with the Claim Form.