Must be received by
March 1, 2017

Stryker Modular Hip Settlement
c/o GCG
Claims Processor
PO Box 10130
Dublin, OH 43017-3130
www.StrykerModularHipSettlement.com

SRY

BLUE CLAIM FORM

ENROLLMENT CLAIM FORM – QUALIFIED REVISION SURGERY
THE STRYKER ABG II/REJUVENATE MODULAR-NECK HIP STEM SETTLEMENT PROGRAM

In order to Enroll in the Stryker ABG II / Rejuvenate Modular-Neck Hip Stem Settlement Program, you must submit this Enrollment Claim Form **no later than March 1, 2017.**

If you are Counsel for a Patient or if you are an Unrepresented Patient (or his or her unrepresented Legal Representative) seeking to Enroll in the Qualified Revision Surgery ("QRS") Program then you must submit this Enrollment Claim Form along with all necessary documentation outlined in this form as part of your Claim Package. **If you are seeking QRS-Related Enhancements, you must apply for those Enhancements as indicated on this Enrollment Claim Form no later than March 1, 2017.** If you are seeking any other non-QRS-Related Enhancements as part of the Enhancements Benefit Program ("EBP"), then you must submit this Enrollment Claim Form and a separate EBP Claim Form. Enrollment for the EBP will commence at a later date and an EBP Claim Form will be available in advance of that date.

The Master Settlement Agreement can be viewed and downloaded at the Settlement Program website, **www.StrykerModularHipSettlement.com**.

If you have any questions or need assistance completing this form, you may contact the Claims Processor by email at:

claimsprocessor@StrykerModularHipSettlement.com

or by calling its toll-free hotline at 1-855-382-6404.

DEFINITIONS FOR ENROLLMENT CLAIM FORM

1. "Affected Product" means the ABG II Modular-Neck hip stem or the Rejuvenate Modular-Neck hip stem.
2. "Broadspire" means Broadspire Services, Inc.
3. "Broadspire Claim" means a claim for a specific reimbursement submitted by a Patient as part of the reimbursement program set up by Stryker following the Voluntary Recall (such program, the "Broadspire Program").
4. "Enhancement Benefit Program" ("EBP") means the supplemental benefits program available pursuant to the Master Settlement Agreement, if applicable.
5. "Enrollment Date" means the date that a Patient enrolls in the Stryker ABG II/Rejuvenate Modular-Neck Hip Stem Settlement Program.
6. "Index Surgery" means the implantation of an Affected Product in a surgery occurring in the United States.
7. "Interest" means any interest in any claims Related to the Affected Products, whether revised or unrevised, in which counsel: (i) has an engagement or retainer agreement with such Patient; (ii) is listed as the counsel of record for a Plaintiff in any filed pleadings Related to the Affected Products; (iii) has entered an appearance for such Plaintiff; (iv) would benefit directly or indirectly from any payment to settle any claim of such Plaintiff or Claimant in connection with the Affected Products; or (v) otherwise has any financial interest of any kind whatsoever in any claim relating to the Affected Products.
8. "Interested Counsel" as used herein means any Counsel with an Interest in a Person, or in a claim or case of a Person who has a Claim, filed or unfiled, Related to the Affected Products.
9. "Legal Representative" means, as to any particular natural person (including a deceased natural person), the estate, executor, administrator, guardian, conservator or other legal representative thereof.
10. "Patient" means the natural person (including the deceased natural person) who was implanted with an Affected Product during an Index Surgery (as opposed to any Legal Representative in respect to such natural person).
11. "Principal Responsible Attorney" means the single attorney identified by the Primary Law Firm by name, state bar number, business address, phone number and email address who will be primarily responsible to provide notice to the applicable court for obligations of the Primary Law Firm relating to the Master Settlement Agreement and for compliance with any court orders entered in the jurisdiction in which the case or claim is pending and shall fulfill the other responsibilities described in the Master Settlement Agreement.
12. "Qualified Revision Surgery" means (i) the Patient underwent a Revision Surgery of an Affected Product, (ii) the Revision Surgery occurred at least 181 days after the Index Surgery, but before December 19, 2016, (iii) the Revision Surgery occurred in the United States, and (iv) the revision surgery involved one (1) or more of the following: (a) an elevated cobalt level, (b) an abnormal diagnostic scan associated with the tissue around the femoral implant related to the reasons underlying the Voluntary Recall, or (c) intra-operative or pathologic confirmation of adverse local tissue reaction ("ALTR"), or aseptic lymphocyte-dominated vasculitis-associated lesion ("ALVAL"), or tissue damage related to the reasons underlying the Voluntary Recall.
13. "QRS-Related Enhancements" means those Enhancements specifically identified in matrix level I(b) of the EBP Award Schedule that took place during the Qualified Revision Surgery, specifically controlled osteotomy, intra-operative femur fracture with osteotomy, intra-operative femur fracture without osteotomy, and surgical repair/reattachment of a damaged abductor muscle complex only.
14. "Related to the Affected Products" as used herein means to any extent, or in any way arising out of, relating to, resulting from and/or connected with the implantation, use and/or removal of the Affected Product(s) and/or any injury, losses, or damages caused or claimed to have been caused, in whole or in part, by any such Affected Product and/or revision to remove the Affected Product(s).
15. "Revision Surgery" means the explantation of both the femoral stem and neck components of the Affected Product.
16. "Settlement Award Payment" means any payment pursuant to the Stryker ABG II/Rejuvenate Modular-Neck Hip Stem Settlement Program.
17. "United States" means the United States of America, its 50 states, the District of Columbia, any Commonwealth or Territory of the United States, and any United States Military Hospital wherever located.
18. "Voluntary Recall" means the June 28, 2012 voluntary recall of the Affected Products from the market issued by Stryker.

A. PERSONAL INFORMATION OF PATIENT

1. Name:

First M.I. Last

2. Current Address:

Street

City State Zip Country

3. Has the Patient resided at this address since his/her Index Surgery? ❑ Yes ❑ No

4. Was the Patient a citizen or legal resident of the United States at the time of the Index Surgery to implant the Affected Product(s)? ❑ Yes ❑ No

5. Telephone Number:

6. Email Address (If Not Represented by an Attorney):

7. Date of Birth:

(mm/dd/yyyy)

8. Date of Death of Patient (if applicable):

(mm/dd/yyyy)

9. Do you claim the Qualified Revision Surgery caused the death?

❑ Yes ❑ No ❑ N/A

10. Social Security Number:

11. Gender:

❑ Male ❑ Female

12. Any Other Names Used or by which the Patient had been known, including but not limited to maiden name and the dates such name(s) were used:

Last First (mm/dd/yyyy)

Last First (mm/dd/yyyy)

B. LEGAL REPRESENTATIVE'S INFORMATION FOR DECEASED OR INCAPACITATED PATIENTS *

13. Does the Patient have a Legal Representative? ❑ Yes ❑ No

If Yes, complete items 14-20. If No, skip to item 21.

14. Reason for Legal Representative? ❑ Patient is Deceased ❑ Patient is Incapacitated

15. Legal Representative's Relationship to Patient:

❑ Estate ❑ Executor ❑ Administrator ❑ Guardian ❑ Conservator ❑ Other _____ (specify)

16. Legal Representative's Name:

First M.I. Last

17. Legal Representative's Address:

Street

City State Zip Country

18. Legal Representative's Telephone Number:

19. Legal Representative's Email Address (If Available):

20. Legal Representative's Social Security Number:

* DOCUMENTATION REQUIREMENT: COURT APPROVAL OR OTHER LEGAL AUTHORIZATION TO REPRESENT THE PATIENT MUST BE ATTACHED, AS SPECIFIED IN SECTION L.

C. PRIMARY LAW FIRM INFORMATION (IF REPRESENTED BY AN ATTORNEY)

21. Is the Patient Represented by an Attorney? ❑ Yes ❑ No

If Yes, complete items 22-32. If No, skip to item 33.

22. Principal Responsible Attorney:

First M.I. Last

23. Firm Name:

24. Firm Address:

Street

City State Zip

25. Telephone Number:

26. Fax Number:

27. Email Address:

28. Date of Retention Agreement with Patient/Plaintiff:

(mm/dd/yyyy)

29. Secondary Administrative Contact Name:

First M.I. Last

30. Position at Firm:

31. Telephone Number:

32. Email Address:

D. INTERESTED COUNSEL INFORMATION (IF APPLICABLE)

33. Is there Interested Counsel Other than the Primary Law Firm?

❑ Yes ❑ No

If Yes, complete items 34-39. If No, skip to item 45.

34. First Interested Counsel's Name:

First M.I. Last

35. Law Firm Name:

36. Current Address:

Street

City State Zip

37. Telephone Number:

38. Email Address:

39. Is there a Second Interested Counsel Other than the Primary Law Firm and First Interested Counsel Listed above?

❑ Yes ❑ No

If Yes, complete items 40-44. If No, skip to item 45.

40. Second Interested Counsel's Name:

First M.I. Last

41. Law Firm Name:

42. Current Address:

Street

City State Zip

43. Telephone Number:

44. Email Address:

E. LAWSUIT AND PLAINTIFF INFORMATION

45. Has a civil action been filed in court alleging injuries as a result of the Patient's Revision Surgery involving an Affected Product?

❑ Yes ❑ No

If Yes, complete items 46-54 as applicable. If no, skip to item 55.

46. Current Court/Jurisdiction:

❑ MDL ❑ MCL ❑ Florida-Broward County ❑ Florida-Palm Beach County

❑ Other (specify)

47. Original Case Caption:

48. Original Case Number:

49. Is the Plaintiff in the civil action the same individual as the Patient identified in Section A or the Legal Representative identified in Section B of this Enrollment Claim Form?

❑ Yes ❑ No

If Yes, skip to item 55. If No, complete items 50-54.

50. Plaintiff's Name:

First M.I. Last

51. Plaintiff's Address:

Street

City State Zip Country

52. Plaintiff's Telephone Number:

53. Plaintiff's Social Security Number:

54. Plaintiff's Relationship to Patient:

❑ Estate ❑ Executor ❑ Administrator ❑ Guardian ❑ Conservator ❑ Other

(specify)

DOCUMENTATION REQUIREMENT: DISMISSAL WITH PREJUDICE STIPULATION, IF APPLICABLE, AS SPECIFIED IN SECTION L.

F. SPOUSE INFORMATION

55. Is the Patient currently married? ❑ Yes ❑ No

If Yes, complete items 56-60. If No, skip to item 61.

56. Spouse's Name:

First M.I. Last

57. Spouse's Date of Birth:

(mm/dd/yyyy)

58. Spouse's Social Security Number:

59. What is the status of the Patient's current relationship with his/her spouse?

❑ Live Together ❑ Separated ❑ Estranged

60. Is the Patient's spouse a named plaintiff in the lawsuit identified in Section E above?

❑ Yes ❑ No

61. If the Patient is not currently married, was s/he married at any time from the date of the Index Surgery until the Enrollment Date?

❑ Yes ❑ No

If Yes, complete items 62 and 63. If No, skip to Section G. Claim Information

62. Former Spouse's Name:

First M.I. Last

63. Select the reason the Patient is no longer married:

❑ Divorced ❑ Death of Former Spouse ❑ Death of Patient

G. CLAIM INFORMATION

64. If the Patient has undergone a Qualified Revision Surgery of an Affected Product, please select one of the following choices that apply to your claim:

❑ Left Hip Only ❑ Right Hip Only ❑ Both Left Hip and Right Hip

If you selected Left Hip Only, complete Section H and skip Section I. If you selected Right Hip Only, complete Section I and skip Section H. If you selected Both Left Hip and Right Hip, complete Section H and Section I.

H. LEFT HIP

65. Indicate the Affected Product Implanted into the Patient:

❑ ABG II Modular-Neck hip stem ❑ Rejuvenate Modular-Neck hip stem

66. Date of Index Surgery:

(mm/dd/yyyy)

67. Location of Hospital Where Index Surgery Occurred:

❑ Hospital Located in the U.S.
❑ Military Hospital Located Outside of the U.S.
❑ Non-Military Hospital Located Outside of the U.S.

68. Was the Index Surgery itself a revision of a prior hip implant? ❑ Yes ❑ No

69. Name of Hospital Where Index Surgery Occurred:

Address Zip Code

70. Name of Index Surgery Surgeon:

Last First Middle Initial

Address Zip Code

71. Date of Revision of Affected Product:

(mm/dd/yyyy)

72. Location of Hospital Where Revision Surgery Occurred:

❑ Hospital Located in the U.S.
❑ Military Hospital Located Outside of the U.S.
❑ Non-Military Hospital Located Outside of the U.S.

73. Name of Hospital Where Revision Surgery Occurred:

Address Zip Code

74. Name of Revision Surgery Surgeon:

Last First Middle Initial

Address Zip Code

75. Reason for the Eligible Revision Surgery (<u>check all that apply</u>):

❑ Elevated cobalt level.
❑ Abnormal diagnostic scan of surrounding tissue related to the reasons underlying the Voluntary Recall.
❑ Intra-operative or pathologic confirmation of adverse local tissue reaction (“ALTR”), aseptic lymphocyte dominated vasculitis-associated lesion (“ALVAL”), or tissue damage related to the reasons underlying the Voluntary Recall.

76. Are you applying for any QRS-Related Enhancements? ❑ Yes ❑ No

77. If Yes, select the QRS-Related Enhancements you are applying for (<u>check all that apply</u>):

❑ Controlled Osteotomy
❑ Intra-Operative Femur Fracture *without* Osteotomy
❑ Intra-Operative Femur Fracture *with* Osteotomy
❑ Surgical Repair/Reattachment of a Damaged Abductor Muscle Complex

<u>DOCUMENTATION REQUIREMENT</u>: ALL RELEVANT MEDICAL RECORDS, AS SPECIFIED IN SECTION L.

I. RIGHT HIP

78. Indicate the Affected Product Implanted into the Patient:

❑ ABG II Modular-Neck hip stem ❑ Rejuvenate Modular-Neck hip stem

79. Date of Index Surgery:

(mm/dd/yyyy)

80. Location of Hospital Where Index Surgery Occurred:

❑ Hospital Located in the U.S.
❑ Military Hospital Located Outside of the U.S.
❑ Non-Military Hospital Located Outside of the U.S.

81. Was the Index Surgery itself a revision of a prior hip implant? ❑ Yes ❑ No

82. Name of Hospital Where Index Surgery Occurred:

Address Zip Code

83. Name of Index Surgery Surgeon:

Last First Middle Initial

Address Zip Code

84. Date of Revision of Affected Product:

(mm/dd/yyyy)

85. Location of Hospital Where Revision Surgery Occurred:

❑ Hospital Located in the U.S.
❑ Military Hospital Located Outside of the U.S.
❑ Non-Military Hospital Located Outside of the U.S.

86. Name of Hospital Where Revision Surgery Occurred:

Address Zip Code

87. Name of Revision Surgery Surgeon:

Last First Middle Initial

Address Zip Code

88. Reason for the Eligible Revision Surgery (check all that apply):

❑ Elevated cobalt level.
❑ Abnormal diagnostic scan of surrounding tissue related to the reasons underlying the Voluntary Recall.
❑ Intra-operative or pathologic confirmation of adverse local tissue reaction (“ALTR”), aseptic lymphocyte dominated vasculitis-associated lesion (“ALVAL”), or tissue damage related to the reasons underlying the Voluntary Recall.

89. Are you applying for any QRS-Related Enhancements? ❑ Yes ❑ No

90. If Yes, select the QRS-Related Enhancements you are applying for (check all that apply):

❑ Controlled Osteotomy
❑ Intra-Operative Femur Fracture *without* Osteotomy
❑ Intra-Operative Femur Fracture *with* Osteotomy
❑ Surgical Repair/Reattachment of a Damaged Abductor Muscle Complex

DOCUMENTATION REQUIREMENT: ALL RELEVANT MEDICAL RECORDS, AS SPECIFIED IN SECTION L.

J. BANKRUPTCY INFORMATION

91. Has the Patient at any time since the date of the Qualified Revision Surgery declared bankruptcy or is the Patient a subject of an open and ongoing bankruptcy proceeding?

❑ Yes ❑ No

If Yes, complete items 90-92. If No, skip to item 93.

92. Bankruptcy Court / Jurisdiction:

93. Date Filed:

(mm/dd/yyyy)

94. Status of Bankruptcy Filing:

❑ Open ❑ Closed (If closed, provide the date closed)

(mm/dd/yyyy)

K. BROADSPIRE INFORMATION (IF APPLICABLE)

95. Has the Patient at any time received any expense reimbursement through the Broadspire Program?

❑ Yes ❑ No

96. Broadspire Claim Number:

L. REQUIRED SUBMISSIONS

In order for your Claim to be reviewed, you must submit all materials required by Section 4.1.2 of the Master Settlement Agreement, including:

- ❑ This properly completed Enrollment Claim Form.
- ❑ The signed and notarized Qualified Revision Surgery Program Release available on the Claims Processor's website.
- ❑ The signed Dismissal with Prejudice Stipulation available on the Claims Processor's website (if applicable). If you indicate on your Stipulation of Dismissal that you are only partially dismissing your lawsuit, you **must** include a copy of the most recent Complaint **filed and served** in your lawsuit.
- ❑ Legal Representative Documentation (if applicable).
- ❑ Manufacturer/product stickers for the Affected Product(s), identifying Product and Lot Codes for the device implanted into the Patient. Only in the event product stickers are not available, please submit the electronic implant log from your Index Surgery. **If the manufacturer/product stickers for the Index Surgery were submitted during the Supplemental Registration Process, you do not need to resubmit.**
- ❑ A true and correct copy of the Index Surgery operative report and discharge summary related to the hip(s) at issue.
- ❑ True and correct copies of the Revision Surgery operative report and discharge summary related to the hip(s) at issue.
- ❑ Specific contemporaneous medical records that document the reason for the eligible Revision Surgery as set forth in Questions 75 and 88 and to support your claim for any QRS-Related Enhancements as set forth in Questions 77 and 90. Such specific medical records must be annotated in a manner that will aid the Claims Processor in reviewing your claim (e.g. highlighting, flagging, bookmarking, etc.). **You must include manufacturer/product stickers identifying the devices and hardware implanted during the Qualified Revision Surgery.** Only in the event product stickers are not available, please submit the electronic implant log from your Qualified Revision Surgery.
- ❑ Progress notes from the treating orthopedic surgeon(s) relating to the hip(s) at issue for the time period from Index Surgery to Revision Surgery.

Counsel or Patients (if unrepresented by an attorney) must **only** provide those documents requested in Section L and shall not submit all medical records in Counsel's and/or Patient's possession. Submitting all documents in your possession will result in the Claims Processor returning your Enrollment Claim Form thereby delaying the review of your claim. All documentation, whether submitted electronically or by mail, must be annotated in a manner that will aid the Claims Processor in reviewing your claim (e.g. highlighting, flagging, bookmarking, etc.).

Pursuant to Section 4.4 of the Master Settlement Agreement, the Claims Processor has the ability to request additional information and/or documents as needed, including but not limited to medical authorizations. Pursuant to Section 4.3.1 of the Master Settlement Agreement, no affidavits, expert reports, depositions, transcripts or medical articles may be submitted in connection with a Claim.

DOCUMENTATION REQUIREMENT: PLEASE CHECK ALL APPLICABLE BOXES ABOVE TO CERTIFY THAT YOU ARE PROVIDING THE RELEVANT FORMS AND DOCUMENTATION.

M. CERTIFICATION BY CLAIMANT

I certify that all of the information provided in and with this Enrollment Claim Form is true and correct to the best of my knowledge, information and belief. I understand that I have the obligation to update the Claims Processor if any information provided in this Enrollment Claim Form changes after it is submitted. I further certify that by participating in this Stryker ABG II/ Rejuvenate Modular-Neck Hip Stem Settlement Program, I agree to abide by the terms of the Agreement and I agree to provide certain additional information and/or documents that the Claims Processor deems necessary to review my claim. If I qualify for a Settlement Award Payment pursuant to the terms of the Agreement, I authorize such Settlement Award Payment to be made to my Counsel identified as my Primary Law Firm in trust for me in accordance with the Agreement, if applicable.

Claimant's Signature: **Date:** (mm/dd/yyyy)

Printed Name:

Last First Middle Initial

N. COUNSEL SIGNATURE (IF APPLICABLE)

Counsel's Signature: **Date:** (mm/dd/yyyy)

Printed Name:

Last First Middle Initial