Must be received by
April 17, 2015
at 5PM EST

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

SRY

ORANGE 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 April 17, 2015 at 5PM EST.**

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 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 planning to Enroll in 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 November 3, 2014, (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. "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).
14. "Revision Surgery" means the explantation of both the femoral stem and neck components of the Affected Product.
15. "Settlement Award Payment" means any payment pursuant to the Stryker ABG II/Rejuvenate Modular-Neck Hip Stem Settlement Program.
16. "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.
17. "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:

Last | First | Middle Initial

2. Current Address:

Street

City | State | Zip | Country

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

4. Telephone Number:

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

6. Date of Birth:

(month/day/year)

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

(month/day/year)

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

☐ Yes ☐ No ☐ N/A

9. Social Security Number:

10. Gender:

☐ Male ☐ Female

11. 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 | (month/day/year)

Last | First | (month/day/year)

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

12. Does the Patient have a Legal Representative? ☐ Yes ☐ No

If Yes, complete items 13-19. If No, skip to item 20.

13. Reason for Legal Representative? ☐ Patient is Deceased ☐ Patient is Incapacitated

14. Legal Representative's Relationship to Patient:

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

15. Legal Representative's Name:

Last | First | Middle Initial

16. Legal Representative's Address:

Street

City | State | Zip | Country

17. Legal Representative's Telephone Number:

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

19. 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)

20. Is the Patient Represented by an Attorney? ☐ Yes ☐ No

If Yes, complete items 21-31. If No, skip to item 44.

21. Principal Responsible Attorney:

Last | First | Middle Initial

22. Firm Name:

23. Current Address:

Street

City | State | Zip

24. Telephone Number:

25. Fax Number:

26. Email Address:

27. Date of Retention Agreement with Patient/Plaintiff:
(month/day/year)

28. Secondary Administrative Contact Name:

Last | First | Middle Initial

29. Position at Firm:

30. Telephone Number:

31. Email Address:

D. INTERESTED COUNSEL INFORMATION (IF APPLICABLE)

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

☐ Yes ☐ No

If Yes, complete items 33-43. If No, skip to item 44.

33. First Interested Counsel's Name:

Last | First | Middle Initial

34. Law Firm Name:

35. Current Address:

Street

City | State | Zip

36. Telephone Number:

37. Email Address:

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

☐ Yes ☐ No

If Yes, complete items 39-43. If No, skip to item 44.

39. Second Interested Counsel's Name:

Last | First | Middle Initial

40. Law Firm Name:

41. Current Address:

Street

City | State | Zip

42. Telephone Number:

43. Email Address:

E. LAWSUIT AND PLAINTIFF INFORMATION

44. 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 45-53 as applicable. If no, skip to item 54.

45. Current Court/Jurisdiction:

46. Case Caption:

47. Original Case Number:

48. 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 54. If No, complete items 49-53.

49. Plaintiff's Name:

Last | First | Middle Initial

50. Plaintiff's Address:

Street

City | State | Zip | Country

51. Plaintiff's Telephone Number:

52. Plaintiff's Social Security Number:

53. 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

54. Is the Patient currently married? ☐ Yes ☐ No

If Yes, complete items 55-59. If No, skip to item 60.

55. Spouse's Name:

Last | First | Middle Initial

56. Spouse's Date of Birth:

(month/day/year)

57. Spouse's Social Security Number:

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

☐ Live Together ☐ Separated ☐ Estranged

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

☐ Yes ☐ No

60. 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 61 and 62. If No, skip to Section G. Claim Information

61. Former Spouse's Name:

Last | First | Middle Initial

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

☐ Divorced ☐ Death of Former Spouse ☐ Death of Patient

G. CLAIM INFORMATION

63. 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

64. Indicate the Affected Product Implanted into the Patient:

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

65. 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

66. Date of Index Surgery:

(month/day/year)

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:

(month/day/year)

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.

<u>DOCUMENTATION REQUIREMENT</u>: PRODUCT IDENTIFICATION FOR AFFECTED PRODUCT(S) AND ALL RELEVANT MEDICAL RECORDS, AS SPECIFIED IN SECTION L.

I. RIGHT HIP

76. Indicate the Affected Product Implanted into the Patient:

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

77. 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

78. Date of Index Surgery:

(month/day/year)

79. 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.

80. Was the Index Surgery itself a revision of a prior hip implant?

☐ Yes ☐ No

81. Name of Hospital Where Index Surgery Occurred:

Address Zip Code

82. Name of Index Surgery Surgeon:

Last First Middle Initial

Address Zip Code

83. Date of Revision of Affected Product:

(month/day/year)

84. 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.

85. Name of Hospital Where Revision Surgery Occurred:

Address Zip Code

86. Name of Revision Surgery Surgeon:

Last First Middle Initial

Address Zip Code

87. 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.

<u>DOCUMENTATION REQUIREMENT</u>: PRODUCT IDENTIFICATION FOR AFFECTED PRODUCT(S) AND ALL RELEVANT MEDICAL RECORDS, AS SPECIFIED IN SECTION L.

J. BANKRUPTCY INFORMATION

88. 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 89-91. If No, skip to item 92.

89. Bankruptcy Court / Jurisdiction:

90. Date Filed:

(month/day/year)

91. Status of Bankruptcy Filing:

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

(month/day/year)

K. BROADSPIRE INFORMATION (IF APPLICABLE)

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

☐ Yes ☐ No

93. 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.
- ☐ 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 medical records that document the reason for the eligible Revision Surgery as set forth in Questions 75 and 87. 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.).
- ☐ 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.

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:** _____
(month/day/year)

Printed Name:

_____ _____ _____
Last First Middle Initial

N. COUNSEL SIGNATURE (IF APPLICABLE)

Counsel's Signature: _____ **Date:** _____
(month/day/year)

Printed Name:

_____ _____ _____
Last First Middle Initial