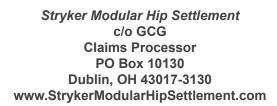
Must be received by March 1, 2017







RED CLAIM FORM

ENROLLMENT CLAIM FORM – COVERED UNREVISED, INFIRM PATIENT THE STRYKER ABG II/REJUVENATE MODULAR-NECK HIP STEM SETTLEMENT PROGRAM

THIS ENROLLMENT CLAIM FORM IS FOR PATIENTS WHO QUALIFY AS COVERED UNREVISED, INFIRM PATIENTS ONLY. The Covered Unrevised, Infirm Patient Program was established as a means to provide awards, pursuant to Article 8 of the Master Settlement Agreement, to certain Patients whose orthopaedic surgeons determined that a Revision Surgery was indicated for the reasons underlying the Voluntary Recall but they have been deemed too infirm to undergo the procedure. The determination of infirmity shall be made by the physician who is treating the Patient for the condition(s) that forms the basis for the infirmity or a medical specialist consulted by the treating physician. The Patient must submit contemporaneous medical records created prior to December 19, 2016 that support his/her claim.

In order to Enroll in the Stryker ABG II / Rejuvenate Modular-Neck Hip Stem Settlement Program, you must submit this Enrollment Claim Form <u>no later than March 1, 2017</u>. If you are Counsel for a Patient or if you are an Unrepresented Patient (or his or her unrepresented Legal Representative) planning to Enroll in the Covered Unrevised, Infirm Patient Program then you must submit this Enrollment Claim Form along with all necessary documentation outlined in this Form as part of your Claim Package.

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

- "Affected Product" means the ABG II Modular-Neck hip stem or the Rejuvenate Modular-Neck hip stem.
- 2. "Covered Unrevised, Infirm Patient" means a Patient whose treating orthopaedic surgeon determines that a Qualified Revision Surgery is indicated for the reasons underlying the Voluntary Recall but that s/he has been determined to be too infirm to undergo the procedure. The determination of infirmity shall be made by the physician who is treating the Claimant for the condition(s) that forms the basis for the infirmity or a medical specialist consulted by the treating physician.
- 3. "Enrollment Date" means the date that a Patient enrolls in the Stryker ABG II/Rejuvenate Modular-Neck Hip Stem Settlement Program.
- 4. "Index Surgery" means the implantation of an Affected Product in a surgery occurring in the United States.
- 5. "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.
- 6. "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.
- 7. "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.
- 8. "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).
- 9. "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.
- 10. "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.
- 11. "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).
- 12. "Revision Surgery" means the explantation of both the femoral stem and neck components of the Affected Product.
- 13. "Settlement Award Payment" means any payment pursuant to the Stryker ABG II/Rejuvenate Modular-Neck Hip Stem Settlement Program.
- 14. "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.
- 15. "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 Repre	esented b	oy an Attorney):		
7. Date of Birth:	8. Date of Death (if applicable	·):			
(mm/dd/yyyy)	(mm/dd/yyyy)				
9. Social Security Number:	10. Gender:				
	Male Fe	emale			
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		(mm/dd/yyyy)		
Last	First		(mm/dd/yyyy)		

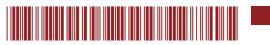


B. LEGAL REPRESENTATIVE'S INFORMATION FOR DECEASED OR INCAPACITATED PATIENTS *

12. Does the	Patient have a	Legal Representati	ve? Yes	No		
		If Yes, comple	ete items 13-19	. If No, skip to	item 20.	
13. Reason fo	or Legal Repre	sentative?	Patient is D	eceased	Patient is Incar	pacitated
14. Legal Re _l	presentative's	Relationship to Pati	ent:			
Estate	Executor	Administrator	Guardian	Conservato	or Other	(specify)
15. Legal Re _l	presentative's	Name:				,
First			M.I.			Last
16. Legal Re _l	presentative's	Address:				
Street						
City			S	tate	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 K.						



C. PRIMARY LAW FIRM INFORMATION (IF REPRESENTED BY AN ATTORNEY)				
20. Is the Patient Represented by an Attorney?	Yes No			
If Yes, complete it	tems 21-31. If No, skip to item	32.		
21. Principal Responsible Attorney:				
First	M.I.		Last	
22. Firm Name:	IVI.I.		Last	
23. Firm Address:				
Street				
City		State	Zip	
24. Telephone Number:	25. Fax Number:			
26. Email Address:				
27. Date of Retention Agreement with Patient/Plain	tiff: (mm/dd/yyyy)			
28. Secondary Administrative Contact Name:				
First	M.I.		Last	
29. Position at Firm:				
30. Telephone Number:				
31. Email Address:				



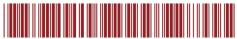
D. INTERESTED COUNSEL INFORMATION (IF A	PPLICABLE)		
32. Is there Interested Counsel Other than the	Primary Law Firm?		
	Yes No		
	ete items 32-38. If No	, skip to item 43.	
33. First Interested Counsel's Name:			
First 34. Law Firm Name:	M.I.		Last
35. Current Address:			
Street			
City 36. Telephone Number:		State	Zip
37. Email Address:			
38. Is there a Second Interested Counsel Other	_	r Firm and First Intereste	ed Counsel Listed above?
	Yes No		
If Yes, comple 39. Second Interested Counsel's Name:	ete items 39-43. If No	, skip to item 44.	
First 40. Law Firm Name:	M.I.		Last
41. Current Address:			
Street			
City 42. Telephone Number:		State	Zip
43. Email Address:			



E. LAWSUIT AND PLAINTIFF INFORMATION

44. Has a civil action been filed in court alleg	44. Has a civil action been filed in court alleging injuries as a result of the Affected Product(s)?				
	Yes No				
If Yes, complete it	ems 45-53 as applicable. If	no, skip to item 54	4.		
45. Current Court/Jurisdiction: MDL MCL Florida-Broward County Other (specify)	Florida-Palm Beach County	y			
46. Original Case Caption:	47. Original C	ase 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:					
First	M.I.		Last		
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 Conserva	ator Other	(specify)		
DOCUMENTATION REQUIREMENT: DISMISSAL	WITH PREJUDICE STIPULATION, I	F APPLICABLE, AS SI	PECIFIED IN SECTION K.		

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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:						
First	M.I.		Last			
56. Spouse's Date of Birth:	57.	. Spouse'	's Social Security Number:			
(mm/dd/yyyy)						
58. What is the status of the Patient's currer	nt relationship wi	th his/he	er spouse?			
Live Toge	ether Sepa	arated	Estranged			
59. Is the Patient's spouse a named plaintif	f in the lawsuit id	entified i	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?						
Emoninent Date:	Yes	No				
If Yes, complete items 61 and 62. If No, skip to Section G. Claim Information						
61. Former Spouse's Name:						
First	M.I.		Last			

G. CLAIM INFORMATION

63. Please select one of the following choices that apply to your claim:

Divorced

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

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

Death of Former Spouse

Death of Patient

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



H. LEFT HIP			
64. Indicate the Affected	Product Implanted into the Pa	tient:	
	ABG II Modular-Neck hip stem	Rejuvenate Modula	ar-Neck hip stem
65. Date of Index Surgery	H N	lospital Located in the U lilitary Hospital Located	
67. Name of Hospital Who	ere Index Surgery Occurred:		
Address			Zip Code
68. Name of Index Surge	ry Surgeon:		
Last		First	Middle Initia
Address			Zip Code
69. Name of Surgeon Ind Recall:	icating that Revision Surgery	is necessary for the re	asons underlying the Voluntary
Last		First	Middle Initia
Address			Zip Code
70. Date on which Revision was Indicated:	on Surgery for the reasons un	derlying the Voluntary	Recall
71. Reason the Revision	Surgery was Indicated (check cobalt level.	all that apply):	(mm/dd/yyyy)
		ssue related to the reas	ons underlying the Voluntary Recall.
	rsician or Consulting Medical S the reasons underlying the Vo		ined the Infirmity that prevents
Last		First	Middle Initia
Address			Zip Code
73. Date on Which Infirm	ity Was Determined by Treatin		
74. Nature of Infirmity:		((mm/dd/yyyy)

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



I. RIGHT HIP		
75. Indicate the Affected Product Implanted into	the Patient:	
ABG II Modular-Neck hip	ip stem Rejuvenate Modular-	Neck hip stem
76. Date of Index Surgery:	77. Location of Hospital Whe	re Index Surgery Occurred:
(mm/dd/yyyy)	Hospital Located in the U.S Military Hospital Located Ou Non-Military Hospital Locate	utside of the U.S.
78. Name of Hospital Where Index Surgery Occu		ed Outside of the O.S.
Address		Zip Code
79. Name of Index Surgery Surgeon:		
Last	First	Middle Initia
Address		Zip Code
80. Name of Surgeon Indicating that Revision Sur	urgery is necessary for the reas	•
Last	First	Middle Initia
		-
Address 84. Data on which Povicion Surgery for the record	and underlying the Volunters D	Zip Code
81. Date on which Revision Surgery for the reason was Indicated:	ons underlying the voluntary Ri	
82. Reason the Revision Surgery was Indicated (Elevated cobalt level.	(check all that apply):	(mm/dd/yyyy)
Abnormal diagnostic scan of surrou	inding tissue related to the reason	s underlying the Voluntary Recall.
83. Name of Treating Physician or Consulting Me Revision Surgery for the reasons underlying		ed the Infirmity that prevents
Last	First	Middle Initia
Address		Zip Code
84. Date on Which Infirmity Was Determined by t	the Treating Physician:	
85. Nature of Infirmity:		(mm/dd/yyyy)

 $\underline{\text{DOCUMENTATION REQUIREMENT:}} \ \ \text{ALL RELEVANT MEDICAL RECORDS, AS SPECIFIED IN SECTION K.}$



J. BANKRUPTCY INFORMATION

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

Yes No

If Yes, complete items 87-89. If No, skip to Section K.

87. Bankruptcy Court / Jurisdiction:

88. Date Filed:

(mm/dd/yyyy)

89. Status of Bankruptcy Filing:

Open Closed (If closed, provide the date closed)

(mm/dd/yyyy)

K. REQUIRED SUBMISSIONS

In order for your Claim to be reviewed, you <u>must</u> submit all materials required by Section 4.2 of the Master Settlement Agreement:

This properly completed Enrollment Claim Form.

The signed and notarized Covered Unrevised, Infirm Patient 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 <u>must</u> include a copy of the most recent Complaint <u>filed and served</u> 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 operative report and discharge summary for the Index Surgery relating to the hip(s) at issue.

True and correct copies of <u>specific</u> contemporaneous medical records <u>created prior to December 19, 2016</u> that support the Patient's claim that a Qualified Revision Surgery is indicated by his/her treating orthopaedic surgeon due to an elevated cobalt level or an abnormal diagnostic scan of surrounding tissue related to the reasons underlying the Voluntary Recall. 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.)

True and correct copies of **specific** contemporaneous medical records **created prior to December 19, 2016** by the treating physician or consulting medical specialist that support the Patient's claim that s/he is too infirm to undergo a Revision Surgery. 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.)

Counsel or Patients (if unrepresented by an attorney) must <u>only</u> provide those documents requested in Section K and shall not submit all medical records in Counsel's and/or Patient's possession. Submitting all records 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.

RED CLAIM FORM



L. 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 Form changes after it is submitted. I further certify that by participating in this Stryker ABG II/

Rejuvenate Modular-Ne provide certain additional acknowledge that if I areductions for any reaso the subject hip is subsequalify for a Settlement A	ent Form changes after it is submitted. I further ck Hip Stem Settlement Program, I agree to ab al information and/or documents that the Claims m eligible for an award, I will receive a flat awarn whatsoever, for each unrevised hip that was imquently revised, I will not be entitled to any additional advanced Payment pursuant to the terms of the Agrees all identified as my Primary Law Firm in trust for near the set of the terms.	ide by the terms of the Processor deems not do f \$75,000, not subsplanted with an Affect and awards as part of the process.	ne Agreement and I agree to eccessary to review my claim. eject to any enhancements or the Product and, to the extent this Settlement Program. If I sh Settlement Award Payment
Claimant's Signature: Printed Name:		Date:	(mm/dd/yyyy)
Last	First		Middle Initial
M. COUNSEL SIGNATU	JRE (IF APPLICABLE)		
Counsel's Signature: Printed Name:		Date:	(mm/dd/yyyy)
Last	First		Middle Initial