Appendix E-1

Claim Form

NUVARING RESOLUTION PROGRAM CLAIM FORM

INSTRUCTIONS

The Claim Package, including a completed copy of this Claim Form, must be submitted no later than the Claim Package Deadline for all Claimants, including unrepresented (*pro se*) Claimants, in the NuvaRing Resolution Program (the "Program") outlined in the Master Settlement Agreement of February 7, 2014 (the "Agreement").

Counsel for Claimants may complete this Claim Form, but the Claimant must personally sign the Certification and Authorization in Section VII. All *Pro Se* Claimants must complete this Claim Form in its entirety.

I.A. CLAIMANT INFORMATION (NuvaRing Product User)

1. Claimant Name	Last	First	Middle
2. Social Security Number	_____ - _____ - _____	**Date of Birth**	_____/_____/_____ (Month/Day/Year)
3. Address	Street/P.O. Box		
	City	State	Zip
4. Telephone Number	(_____) _____-_____	**5. Email**	
6. Any other names by which Claimant has been known, including but not limited to maiden name:	Last	First	Middle
	Last	First	Middle
	Last	First	Middle

I.B. PRIMARY COUNSEL INFORMATION

1. Attorney Name	Last	First	Middle	
2. Firm Name	Law Firm			
3. Address	Street			
	City	State	Zip	Country
4. Telephone Number	(_____) _____-_____	**5. Facsimile**	(_____) _____-_____	
6. Email				

I.C. CASE INFORMATION (if applicable)	
1. Court/Jurisdiction	
2. Case Caption	_____ v. _____
3. Case No.	

II. PERSONAL REPRESENTATIVE INFORMATION FOR MINOR, DECEASED, OR INCAPACITATED CLAIMANTS				
1. Does the Claimant have a Representative? **YES** ☐ **NO** ☐ If Yes, complete this Section II. If No, skip to Section III.				
2. Relationship to Claimant (check all that apply)	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Administrator ☐ Executor ☐ Other _____ (specify)			
3. Representative's Name	Last	First	Middle	
4. Representative's Address	Street			
	City	State	Zip	Country
5. Representative's Telephone Number	(_____) _____-_____	**6. Email**		
7. SSN	___-___-___	**8. Date of Birth**	___/___/___ (Month/Day/Year)	
9. Death of Claimant (if applicable)	___/___/___ (Month/Day/Year)	**10. Do you claim that NuvaRing caused the Death?** (if applicable)	**YES** ☐	**NO** ☐

III. CLAIM INFORMATION

Fill in the injury or injuries Claimant is claiming from her use of NuvaRing and indicate the date(s) of occurrence. To be eligible for compensation under the Agreement, the alleged injury must have occurred (i) prior to February 7, 2014 (the Execution Date of the Settlement Agreement), and (ii) after the Claimant was first prescribed or provided NuvaRing. Claimant must submit medical records that confirm diagnosis of the injury she claims, as outlined in Section IV of the Claim Form and in Section 3.02 of the Agreement.

	ALLEGED INJURY	DATE
		_____/_____/_____ (Month/Day/Year)
		_____/_____/_____ (Month/Day/Year)
		_____/_____/_____ (Month/Day/Year)

IV. CLAIM PACKAGE MATERIALS

Attach all Claim Package materials as required by Section 3.02 of the Agreement. Indicate that you are submitting the following by checking the box(es) below:

☐	A completed and signed Claim Form.
☐	A completed and signed Authorization to Release Records and Other Information contained in Appendix E-2 of the Agreement. The Claims Administrator can provide this form. When executing this document, the Claimant shall not specify particular healthcare providers for the collection of records, but shall leave the provider field of the form blank so that it may be utilized for collection of any necessary records in accordance with Section 4.06 of the Agreement.
☐	A signed Release in the form contained in Appendix F-1 or F-2 of the Agreement, as applicable. The Claims Administrator can provide the form Release.
☐	Prescription Records reflecting the prescription of NuvaRing to Claimant created at or about the time the health care provider wrote the prescription(s) for or provided NuvaRing to Claimant.
☐	Medical Records reflecting the Claimant's diagnosis of the alleged injury or injuries listed in Section III above, created at or about the time the diagnosis was made.
☐	A Stipulation of Dismissal that meets the requirements of the court in which Claimant's case was filed. (Not required to be submitted by Qualifying Unfiled Program Participants.)
☐	An executed Identification of Potential Third-Party Claimants contained in Appendix H-1 of the Agreement. The Claims Administrator can provide this form.
☐	Wire instructions for use by the QSF Administrator as specified in Section 3.02(A)(8) of the Agreement. The Claims Administrator will make this form available.

V. CLAIMANT'S ELIGIBILITY FOR MEDICARE OR MEDICAID

A. Pursuant to the requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, codified at 42 U.S.C. 1395y(b)(7) and (b)(8), Claimant and Counsel for Claimant represent and warrant that the following information provided in this form is complete and accurate: (1) the Claimant's Social Security Number; (2) the Claimant's full legal name; and (3) the Claimant's date of birth.

B. Certification Relating to Medicare and Medicaid Eligibility:

To the best of her knowledge, Claimant certifies, by indicating below, that she

- ☐ **IS** currently eligible to receive Medicare benefits.
- ☐ **IS NOT** currently eligible to receive Medicare benefits.
- ☐ **IS** currently eligible to receive Medicaid benefits.
- ☐ **IS NOT** currently eligible to receive Medicaid benefits.

VI. CLAIMANT'S CERTIFICATION REGARDING BANKRUPTCY

Claimant certifies, by indicating below, that she

- ☐ **IS** a party in a bankruptcy action currently pending in which she is seeking bankruptcy protection.
- ☐ **IS NOT** a party in a bankruptcy action currently pending in which she is seeking bankruptcy protection.

VII. CERTIFICATION, AUTHORIZATION AND SIGNATURE

By submitting this Claim Form, I agree to be bound by the terms of the Agreement and the jurisdiction of the Special Master, and the court presiding over MDL No. 1964, the federal multi-district litigation venued in the United States District Court for the Eastern District of Missouri (the "MDL Court") (or the New Jersey Coordinated Proceeding Court, should the MDL Court lack subject matter jurisdiction), with regard to all matters pertaining to the Agreement and the Program contained therein. I agree that the Special Master will hear motions to dismiss claims that fail to comply with the Agreement and make recommendations to the court in which my case is pending. I also agree that appeals of determinations by the Claims Administrator as to whether a Claimant is eligible for payment under the terms of the Master Settlement Agreement will be resolved by the Special Master, and that the Special Master's decisions will be binding on the parties. I acknowledge that the Special Master's rulings on these appeals are separate from recommendations he makes as a Special Master on appointment from the MDL Court, New Jersey Coordinated Proceeding Court, or other court. By executing this form, I acknowledge that I have been fully advised of my rights under the Agreement and elect to participate in the Program, and that such election is irrevocable.

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Claim Form is true and correct.

Claimant's Signature			**Date**	_____/_____/_____ (month) (day) (year)
Printed Name	First	MI	Last	