APG Silica Trust

Submit completed claims to:

APG Silica Trust
c/o Verus Claims Services, LLC
3967 Princeton Pike, Princeton, NJ 08540
trustsupport@verusllc.com
www.apgsilicatrust.org

APG SILICA TRUST
CLAIM FORM

Instructions for the Claim Form

Complete this Claim Form as thoroughly and accurately as possible. Please type or print neatly. Should there be insufficient space to list all relevant information for any item, please attach additional sheets (*include Claimant's name and Social Security number at the top of each additional sheet submitted*). Please check the box and submit each of the following with this Claim Form that is applicable to this claim:

- ☐ Diagnosis of silica-related disease and required Medical Records
- ☐ Proof of Industry Exposure (credible third-party evidence such as social security records—see the Trust Distribution Procedures for details)
- ☐ Supporting materials for claims seeking Individual Review for enhanced claim valuation (Type 2 Claims)
- ☐ Death Certificate (if applicable)
- ☐ Letters Testamentary or estate documentation pursuant to applicable law or Certificate of Official Capacity (if Claimant Representative is filing form) or Attorney Certification and Warranty of Claimant Representative's Authority executed below

Representation by Counsel

If the Law Firm has not registered with the Trust, please contact the Trust to register at the address for submission of claims above.

NOTICE REGARDING REPORTING TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES

THE APG SILICA TRUST IS REQUIRED TO, AND WILL, REPORT ALL PAYMENTS MADE TO OR FOR THE BENEFIT OF CLAIMANTS FOR WHICH REPORTING IS REQUIRED TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES, WHICH MAY SEEK TO RECOVER A PORTION OF THOSE PAYMENTS FROM CLAIMANTS TO RECOVER MEDICARE OR MEDICAID BENEFITS PAID TO OR FOR THE INJURED PARTY ON ACCOUNT OF A SILICA-RELATED DISEASE.

Injured Party:_____SSN:_____

Part 1: Type of Claim

Please choose the applicable type of claim (choose only one):

- ☐ Type 1 (Expedited Review) Claim
- ☐ Type 2 (Individual Review) Claim
- ☐ Type 3 (Convenience Class) Claim

NOTE: All claims will be considered for the type of claim that is supported by the evidence submitted, regardless of which box is checked.

Part 2: Injured Party/Claimant Information

NOTE: As used in this Claim Form, the "Claimant" is the person filing the Claim Form directly or through a licensed attorney. The Claimant may be the "Injured Party" who is the person with a silica-related disease from occupational or secondary exposure, or a "Claimant Representative" who is the representative of the Injured Party or the Injured Party's estate or heirs.

A. Injured Party's Full Name:_____

Street Address:_____ City:_____

State:_____ Country:_____ Zip:_____

SSN:_____ Daytime Phone: (____)_____

Date of Birth:____/____/_____ If deceased, Date of Death___/_____/_____

Gender: ☐ Male ☐ Female

B. If the Claim is being filed by a Claimant Representative, other than the licensed attorney submitting this claim form, provide the following for the Claimant Representative:

1. Full Name:_____

   Street Address:_____ City:_____

   State:_____ Country:_____ Zip:_____

   Daytime Phone: (_____)_____

2. Claimant Representative's Capacity (***choose one***):

   ☐ Executor / Administrator / Trustee ☐ Guardian

   ☐ Attorney-In-Fact ☐ Other (specify):_____

Part 3: Diagnosed Silica-Related Injuries

Indicate the highest level (most serious) silica-related disease that has been diagnosed for the Injured Party and for which medical documentation is submitted with this Claim Form.

√	**Disease Level**	**Disease Description**	**Date of Diagnosis** mm/dd/yyyy
	I	Simple Silicosis	___/___/_____
	II	Severe Silicosis	___/___/_____
	III	Lung Cancer	___/___/_____
	IV	Complicated Silicosis	___/___/_____

The claim must meet the relevant criteria and be supported by appropriate documentation and credible evidence as described in the Trust Distribution Procedures. **All claims will be considered for the highest disease category that is supported by the evidence submitted, regardless of which disease is checked.** A summary of the presumptive Medical Criteria for the four Disease Levels listed above is set forth in the Instructions to this Claim Form, but in the event of any inconsistency between such summary and the provisions of the Trust Distribution Procedures, the provisions of the Trust Distribution Procedures shall control.

Part 4: Injured Parties with Dual Claims

1. Has the Injured Party ever received a diagnosis of Lung Cancer based on an underlying asbestos disease?

   ☐ Yes ☐ No

2. Has the Injured Party filed a claim against an APG Entity or the APG Asbestos Trust for an asbestos-related disease?

   ☐ Yes ☐ No

   If Yes, provide the name of the asbestos-related disease.

√	**Disease Description**
	Mixed Dust Disease
	Pleural Disease
	Asbestosis
	Colon Cancer
	Epiglottal Cancer
	Esophageal Cancer
	Gastrointestinal Cancer
	Laryngeal Cancer
	Lung Cancer
	Mesothelioma
	Pharyngeal Cancer
	Rectal Cancer
	Stomach Cancer
	Other Cancer

3. Has the Injured Party received a settlement from the APG Asbestos Trust for Lung Cancer?

   ☐ Yes ☐ No

   If Yes, what was the Allowed Liquidated Value? $_____

Part 5: Claimant's Jurisdiction

1. State the Claimant's Jurisdiction: _____

2. What is the basis for the jurisdiction selected? (Select each that is applicable)

   ☐ Jurisdiction in which a claim was filed against an APG Entity in the tort system prior to February 14, 2002. For a list of APG Entities, see Exhibit A to the Trust Distribution Procedures.

   ☐ Jurisdiction in which the Injured Party resided at the time of diagnosis of the silica-related disease that is the basis for this claim

   ☐ Jurisdiction in which the Injured Party resides at the time of filing a claim against the APG Silica Trust

   ☐ Jurisdiction in which the Injured Party experienced exposure to a silica-containing product manufactured or distributed by an APG Entity

Part 6: Industry Exposure and Occupational Exposure

Proof of Industry Exposure must be provided for all Type 1 and Type 2 Claims as required by the Trust Distribution Procedures. In addition, proof of Occupational Exposure must be submitted as support for enhanced claim valuation for Type 2 (Individual Review) Claims. If the Injured Party claims secondary exposure (see Part 7), proof of Industry Exposure (for Type 1 and Type 2 Claims) must be provided for the occupationally exposed person ("OEP") who is the basis for the secondary exposure claim, and proof of Occupational Exposure for the OEP who is the basis for the secondary exposure claim must be submitted for a Type 2 Claim. Convenience Class Claimants (Type 3 Claims) must provide dates of first and last exposure to respirable silica in Section B1 below, even if the Convenience Class Claimant is not providing Industry or Occupational Exposure information.

Was the Injured Party an employee of an APG Entity? For a list of APG Entities, see Exhibit A to the Trust Distribution Procedures.

☐ Yes ☐ No

A. If so, during what years? (yyyy) ____ to (yyyy) ____

B. Industry and Occupational Exposure: Complete for each claimed Industry Exposure. If more space is needed, please photocopy this page, and insert after current page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B1:

1. Name of Plant /Site of Exposure: _____
   _____

   City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
   Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
   _____
   _____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 6, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 6, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation, and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B2:

1. Name of Plant /Site of Exposure: _____
   _____

   City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
   Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
   _____
   _____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 6, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 6, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B3:

1. Name of Plant /Site of Exposure: _____
   _____

   City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
   Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
   _____
   _____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 6, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 6, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B4:

1. Name of Plant /Site of Exposure: _____
_____

   City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
   Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
_____
_____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 6, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 6, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Industry Codes Table

A.	Primary Steel and Iron Manufacturing
B.	Aluminum Manufacturing
C.	Cement Plants
D.	Ferrous and Non-Ferrous Foundries
E.	Furnace Manufacturers and Contractors
F.	Glass and Ceramics Plants
G.	Copper Smelting

Occupation Codes Table

1. Brickmasons (including bricklayers and brickhackers)	8. Pourers
2. Refractory materials repairers and helpers (construction and maintenance of ladles, furnaces & kilns)	9. Ladle liners
3. Furnace tenders	10. Pattern makers
4, Millwrights	11. Equipment operators (transport of refractory products)
5, Boiler room workers (operators and maintenance)	12. Material handlers (refractory products)
6. Molders and Casters	13. Laborers, general maintenance and custodial staff working in proximity of refractory products
7. Coremakers	14. Supervisors of any of the above
	15. Sandblasters
	16. Laborers, general maintenance and custodial staff working in proximity to sandblasting operations

C. Alternate Industry Exposure. If the Injured Party did not have a minimum of six months of cumulative exposure in one of the industries for which an Industry Code is listed above for any of the claimed Exposures, provide for each of those Exposures the following information and credible evidence of six months or greater cumulative exposure to respirable silica as a result of handling, installing, using, repairing, tearing out or cleaning out silica-containing refractory products manufactured or distributed by an APG Entity or working on a regular basis in close proximity to workers engaged in such activities. Provide the following information for each job site that the Injured Party is relying upon in order to establish such exposure: If more space is needed, please photocopy this page, complete for each such Exposure (with the corresponding Exposure number) and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B__ (enter corresponding Exposure number from Part 6, Section B)

a. Job Site: _____

b. City/State: _____

c. Industry: _____

d. Name(s) of silica-containing refractory product(s) manufactured or distributed by an APG Entity to which exposure is claimed: _____
_____
_____
_____

Exposure B__ (enter corresponding Exposure number from Part 6, Section B)

a. Job Site: _____

b. City/State: _____

c. Industry: _____

d. Name(s) of silica-containing refractory product(s) manufactured or distributed by an APG Entity to which exposure is claimed: _____
_____
_____
_____

D. Alternate Occupational Exposure. If any claimed Exposure above is not completed with an Occupation Code because the Occupation in which the Exposure occurred is not listed, provide the following information to identify the name, nature and duties of each Occupation in which such Exposure occurred as follows: If more space is needed, please photocopy this page, complete for each such Exposure (with the corresponding Exposure number) and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*). Note: Occupational Exposure is not required for a Type 1 claim but must be submitted as a factor for consideration in valuing a Type 2 Claim.

Exposure B__ (enter corresponding Exposure number from Part 6, Section B)

a. Name of Occupation: _____

b. Nature of Occupation and Duties: _____
_____
_____

c. Select one or more:

i. ____ Handled, installed, used, repaired, tore out or cleaned out silica-containing refractory products manufactured or distributed by an APG Entity; or

ii. ____ Worked on a regular basis in close proximity to workers who did one or more of the above activities; or

iii. ___Other (please describe in detail): _____
_____
_____
_____
_____
_____
_____

Exposure B__ (enter corresponding Exposure number from Part 6, Section B)

a. Name of Occupation: _____

b. Nature of Occupation and Duties: _____
_____
_____

c. Select one or more:

i. ____ Handled, installed, used, repaired, tore out or cleaned out silica-containing refractory products manufactured or distributed by an APG Entity; or

ii. ____ Worked on a regular basis in close proximity to workers who did one or more of the above activities; or

iii. ___Other (please describe in detail): _____
_____
_____
_____
_____
_____
_____

Part 7: Exposure to an Occupationally Exposed Person

Is the Injured Party alleging a silica-related disease resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)?

☐ Yes ☐ No

If yes, complete the following and Part 6 for each OEP.

OEP's Full Name:_____

Home Address:_____City:_____

State:_____Country:_____Zip:_____

SSN:_____

Date of Birth:__/_____/_____ If deceased, Date of Death__/_____/_____

Date Exposure to OEP began: (mm/yyyy) ___/____

Date Exposure to OEP ended: (mm/yyyy) ___/____

Relationship of Injured Party to OEP:

I am his/her _____
(brother, son, spouse, etc.)

Describe how the Injured Party was exposed to silica-containing refractory product(s) manufactured or distributed by an APG Entity through the OEP:

_____

_____

_____

_____

_____

_____

_____

_____

Reminder: Part 6 must be completed for the OEP.

Part 8: Smoking History

NOTE: This information is relevant only to Type 2 (Individual Review) Claims. This section is not required to be completed if your claim is for a Type 1 (Expedited Review) or a Type 3 (Convenience Class) Claim.

For each item, indicate whether the Injured Party smoked the given product. If the Injured Party stopped smoking prior to death, enter the last date the Injured Party smoked.

Has the Injured Party ever:

Smoked Cigarettes? ☐ Yes ☐ No

If "Yes" is checked and the Injured Party stopped smoking prior to death, enter the last date the Injured Party smoked: (mm/yyyy) ___/____

Has the Injured Party ever:

Smoked Cigars? ☐ Yes ☐ No

If "Yes" is checked and the Injured Party stopped smoking prior to death, enter the last date the Injured Party smoked: (mm/yyyy) ___/____

Part 9: Individual Review Factors

NOTE: This section is optional and is only required to be completed if you want this information to be considered in connection with enhanced claim valuation for a Type 2 (Individual Review) Claim. Proof of Occupational Exposure under Part 6 must also be provided for consideration in connection with enhanced claim valuation for a Type 2 Claim.

A. Describe any unusual or extraordinary financial loss, including lost wages or medical expenses that you assert should entitle you to receive more than the Scheduled Value for the highest disease category for which your claim qualifies: The Trust's valuation process automatically calculates and considers lost wages to age 65, but the Claimant can submit more specific information by completing an Expense Worksheet which is available on request from the Trust to use in submitting information on medical expenses and lost wages as economic loss.

B. The Injured Party has a total of ________________dependents. Provide the information below for each dependent. Be sure to include the Injured Party's spouse and/or any dependents who derive (or who did derive at the time of the Injured Party's death) at least one-half of their financial support from the Injured Party. Also list beneficiaries represented by Injured Party's counsel who are entitled to pursue an action for wrongful death under applicable state law. If more than four, please photocopy this page, and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other___________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other___________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other___________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other___________________

C. Describe any claimed special damages attributable to the claimed silica-related disease: ____
____

D. Describe any claimed extraordinary impairment attributable to the claimed silica-related disease: ____
____

Injured Party:____________________________________SSN:______________________

Part 10: Signature Page

All claims must be signed by the Claimant, or the person filing on his/her behalf (such as the Claimant Representative or attorney).

If signed below by the Claimant or the Claimant Representative, the undersigned certifies, under penalty of perjury, as follows: I have reviewed the information submitted on this Claim Form and all documents submitted in support of this claim. To the best of my knowledge the information submitted is accurate and complete.

If signed below by the attorney for the Claimant or the Claimant Representative, the undersigned certifies, under penalty of perjury, as follows: I am authorized to file this Claim Form; I, or other trained personnel within my firm, have reviewed the information submitted on this Claim Form and all documents submitted in support of this claim; and to the best of my knowledge, based on policies and procedures adopted and implemented by my firm concerning claims processing, the information submitted is true, accurate and complete, and/or the information is included within the Claimant's file and is derived from information provided by the Injured Party, one or more of the Injured Party's co-workers or the Injured Party's medical experts.

I consent to the furnishing of the name and social security number of the Claimant and the Injured Party and the name of the attorney (if any) representing the Claimant and the Injured Party and all claims materials and supporting evidence and documentation to the APG Asbestos Trust or any APG Entity pursuant to, and subject to the conditions set forth in, Section 2.2(e) of the Trust Distribution Procedures.

CLAIMANT ACKNOWLEDGES THAT THE APG SILICA TRUST IS REQUIRED TO, AND WILL, REPORT ALL PAYMENTS MADE TO OR FOR THE BENEFIT OF CLAIMANTS FOR WHOM REPORTING IS REQUIRED TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES, WHICH MAY SEEK TO RECOVER A PORTION OF THOSE PAYMENTS FROM CLAIMANTS TO RECOVER MEDICARE OR MEDICAID BENEFITS PAID TO OR FOR THE INJURED PARTY ON ACCOUNT OF A SILICA-RELATED DISEASE.

Claimant consents to any required reporting by the APG Silica Trust to the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services and/or any other agency or successor entity charged with responsibility for monitoring, assessing, or receiving reports made under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173), or any other similar statute or regulation, and any related rules, regulations, or guidance issues or amendments or amendatory statutes passed in connection therewith (collectively, "CMS"), the name and the social security number of, and amounts the APG Silica Trust has agreed to pay to, Claimant and other information required to be reported to CMS if Claimant has an allowed APG Silica Trust Claim. In addition Claimant consents to the APG Silica Trust reporting such information to the APG Entities and certain insurers if required on the

terms and under the circumstances described in the APG Silica Trust Agreement. In the absence of satisfaction or waiver of any CMS subrogation lien, it is anticipated that CMS will require each Claimant to reimburse CMS, in its role as secondary payor, for some or all of any funds previously paid by CMS, and not yet recovered or settled and released, for medical care of the Claimant or Injured Party, as applicable, on account of a Silica-related disease.

Claimant hereby CERTIFIES that Claimant has provided or will provide for the payment and/or resolution of any obligations owing or potentially owing by Claimant or the Injured Party from any award to Claimant by the APG Silica Trust under 42 U.S.C. § 1395y *et seq.*, or any other similar statute or regulation, and any related rules, regulations, or guidance issued in connection therewith or amendments thereto, including Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173), or any other similar statute or regulations, and any related rules, regulations, or guidance issued or amendments or amendatory statutes passed in connection therewith.

Signatures and Certification

_____

Signature of Claimant, Claimant Representative or attorney

_____

Please print the name and relationship to the Claimant of the signatory above.

Attorney Certification and Warranty of Claimant Representative's Authority

This section must be executed by the Attorney only if (i) the Injured Party has a Claimant Representative and (ii) neither Letters Testamentary or estate documentation pursuant to applicable law nor a Certificate of Official Capacity is submitted with this claim form. The Attorney certifies and warrants that this claim is filed on behalf of the Injured Party by the Claimant Representative and that the Claimant Representative is authorized by law to file this claim on behalf of the Injured Party.

_____

Signature of Attorney/Name of Firm