

Kaiser Aluminum & Chemical Asbestos PI Trust Claim Form

General Instructions for filing this Claim Form:

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; *submitting an incomplete form may result in delays in processing, and/or the Trust may not be able to assign the claim a position in the FIFO processing queue.* Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the Type of Review that best suits the injured party's situation.

Expedited Individualized Extraordinary Secondary Exposure Foreign Claim

Check the appropriate box to elect Exigent treatment: Exigent Hardship Exigent Health

Section 1: Injured Party Information				Firm's Matter Number for this Claim:		
Last Name		First Name		Middle Name		Suffix
Social Security Number or Foreign Tax ID	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Death (mm/dd/yyyy)	Was death asbestos related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address (if not represented by counsel)					Daytime Telephone	
City	State	ZIP Code	Country	Email Address		

Section 2: Law Firm / Attorney Information

If the injured party is represented by counsel, please provide the following information:

Law Firm Name				Filer ID		
Mailing Address						
City			State	ZIP Code		
Attorney Last Name		Attorney First Name		Attorney Middle Name		Suffix
Direct Telephone	Facsimile		Email Address			

Section 3: Asbestos Related Injury

Check the box next to the highest Disease Level the injured party is claiming.

Disease Level	
<input type="checkbox"/> Other Asbestos Disease (Level I) <input type="checkbox"/> Asbestosis/Pleural Disease (Level II) <input type="checkbox"/> Asbestosis/Pleural Disease (Level III)	
<input type="checkbox"/> Severe Asbestosis (Level IV) <input type="checkbox"/> Other Cancer (Level V) <input type="checkbox"/> Lung Cancer 2 (Level VI)	
<input type="checkbox"/> Lung Cancer 1 (Level VII) <input type="checkbox"/> Mesothelioma (Level VIII)	
Diagnosis Date (mm/dd/yyyy)	If Other Cancer (Level V), please specify malignancy:

**Kaiser Aluminum & Chemical Asbestos PI Trust
Claim Form**

Section 4: Smoking History (Not Required for Expedited Review)

In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of packs or cigars smoked per day. Indicate fractional packs or cigars as decimals (e.g. enter ½ pack per day as 0.5)

Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day

Section 5: Personal Representative (if injured party is deceased or incompetent)

Last Name		First Name		Middle Name		Suffix
Social Security Number or Foreign Tax ID		Capacity of Personal Representative (i.e. Administrator, Executor, Guardian, etc.)				
Mailing Address (If injured party is not represented by counsel)					Daytime Telephone	
City		State	ZIP Code		Country	

Kaiser Aluminum & Chemical Asbestos PI Trust Claim Form

Section 7: Occupational Exposure to Asbestos Products

Provide the information below for each location at which claimant alleges exposure to asbestos occurred. Please include detail for all asbestos exposure which you think is sufficient to meet the criteria for the approval of the claim at the claimed disease level. List each site, industry and occupation combination separately. If the exposure site is on the approved Kaiser Aluminum & Chemical site list (provided as Exhibit A), enter the site code in the space provided. Otherwise, provide the complete name and location of each individual site. *Attach additional copies of this page if more space is required.*

Exposure Site 1

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Kaiser Aluminum & Chemical products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

Exposure Site 2

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Kaiser Aluminum & Chemical products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

Exposure Site 3

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation	Approved Site Code
Site of Exposure (i.e. Plant or Site Name)		City	State
Industry in which exposure occurred (see Exhibit A for list of Industry Codes):		If Other, please specify	
Name of all Kaiser Aluminum & Chemical products to which injured party was exposed			
Describe the circumstances of asbestos exposure:			

**Kaiser Aluminum & Chemical Asbestos PI Trust
Claim Form**

Section 7 (cont'd): Occupational Exposure to Asbestos Products

If the claimant is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the injured party satisfies Section 5.4(a) of the TDP:

Section 8: Secondary Exposure (Not Applicable for Expedited Review)

If the injured party's asbestos exposure was due in whole or in part to exposure to an Occupationally Exposed Person, complete Section 7, Part 1 with the exposure information for the occupationally exposed person, and provide the information below:

Date Exposure to Other Person Began (mm/dd/yyyy)	Date Exposure to Other Person Ended (mm/dd/yyyy)	Relationship to Occupationally Exposed Person	SSN of Occupationally Exposed Person
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Description of how injured party was exposed to Kaiser Products through Occupationally Exposed Person:

Section 9: Employment / Earnings information (Not Required for Expedited Review)

If economic losses are being claimed, you must enclose an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Partially Disabled <input type="checkbox"/> Fully Disabled <input type="checkbox"/> N/A (Deceased)	
Amount of Last Annual Wages	Date of Last Wage Received (mm/dd/yyyy)

**Kaiser Aluminum & Chemical Asbestos PI Trust
Claim Form**

Section 10: Dependents (Not Required for Expedited Review)

List the injured party's spouse and any other dependents. *Attach additional copies of this page if more space is required.*

Dependent 1

Last Name		First Name		Middle Name	Suffix
Relationship to Injured party	If "Spouse", was dependent a party to a lawsuit filed on injured party's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 2

Last Name		First Name		Middle Name	Suffix
Relationship to Injured party	If "Spouse", was dependent a party to a lawsuit filed on injured party's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 3

Last Name		First Name		Middle Name	Suffix
Relationship to Injured party	If "Spouse", was dependent a party to a lawsuit filed on injured party's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 4

Last Name		First Name		Middle Name	Suffix
Relationship to Injured party	If "Spouse", was dependent a party to a lawsuit filed on injured party's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent 5

Last Name		First Name		Middle Name	Suffix
Relationship to Injured party	If "Spouse", was dependent a party to a lawsuit filed on injured party's behalf? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Kaiser Aluminum & Chemical Asbestos PI Trust
Claim Form**

Section 11: Certification and Signature

This claim form must be signed by the claimant's attorney, or if not represented by an attorney, the claimant or his/her personal representative.

I have reviewed the information provided on this claim form, and all documents submitted in support of this claim. I hereby certify, under penalty of perjury, that this information is accurate and complete to the best of my knowledge, and that all available documentation has been provided as required by the Trust Distribution Procedures, including but not limited to all medical reports required by Sections 5.7(a)(1)(A), 5.7(a)(1)(B) and 5.6(a)(1)(C) therein.

Signed	Date Signed
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Print Name Here

To file by mail, send this completed form and all supporting documentation to:

KACC Asbestos PI Trust
c/o Verus Claims Services, LLC
57 Hamilton Avenue, Suite 208
Hopewell, NJ 08525

**Kaiser Aluminum & Chemical Asbestos PI Trust
Claim Form**

Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form:

For living and deceased claimants:

- Medical records supporting the diagnosis of the claimed Disease Level
- Proof of Kaiser product exposure, as required by the TDP

For all deceased claimants:

- Death certificate
- Letters of Administration or other proof of personal representative's official capacity

For Exigent Hardship Claims and/or claimants asserting a claim for Lost Wages:

- Documentation supporting the claim that any and all wage loss incurred by the claimant was the direct result of claimant's asbestos-related disease. This documentation would include, but not be limited to medical records and/or reports, reports from governmental or insurance agencies and/or reports from claimant's most recent employer.
- Tax returns and/or W-2 forms for the last three (3) full years of employment.

For "Dual Claimants" only:

- Copy of CTPV release executed as to Kaiser Aluminum & Chemical Corporation or the Kaiser CTPV PI Trust (if applicable)
- Copy of silica release executed as to Kaiser Aluminum & Chemical Corporation or the Kaiser Silica Trust (if applicable)