# 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 | Date of Death (mm/dd/yyyy) | Was death asbestos related? |
|---|---|---|---|---|
| | | Male Female | | Yes 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

☐ Other Asbestos Disease (Level I) ☐ Asbestosis/Pleural Disease (Level II) ☐ Asbestosis/Pleural Disease (Level III)

☐ Severe Asbestosis (Level IV) ☐ Other Cancer (Level V) ☐ Lung Cancer 2 (Level VI)

☐ Lung Cancer 1 (Level VII) ☐ Mesothelioma (Level VIII)

| Diagnosis Date (mm/dd/yyyy) | If Other Cancer (Level V), please specify malignancy: |
|---|---|
| | |

## 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 1/2 pack per day as 0.5)

| Product | Start Date (mm/dd/yyyy) | Quit Date (mm/dd/yyyy) | Packs/Cigars Per Day |
|---|---|---|---|
| Cigarettes Cigars | | | |
| Product | Start Date (mm/dd/yyyy) | Quit Date (mm/dd/yyyy) | Packs/Cigars Per Day |
| Cigarettes Cigars | | | |
| Product | Start Date (mm/dd/yyyy) | Quit Date (mm/dd/yyyy) | Packs/Cigars Per Day |
| Cigarettes Cigars | | | |
| Product | Start Date (mm/dd/yyyy) | Quit Date (mm/dd/yyyy) | Packs/Cigars Per Day |
| Cigarettes Cigars | | | |
| Product | Start Date (mm/dd/yyyy) | Quit Date (mm/dd/yyyy) | Packs/Cigars Per Day |
| Cigarettes Cigars | | | |

## 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 6: Asbestos Litigation and Claims History

If an asbestos-related lawsuit has ever been filed on behalf of the injured party, provide the following information:

| File Date (mm/dd/yyyy) | State | Court |
|---|---|---|
| | | |

| Docket Number | Kaiser Named? |
|---|---|
| | Yes<br>N |

| Has injured party received settlement monies related to this lawsuit from Kaiser or its insurer? | If "yes", Amount: |
|---|---|
| Yes No | |

| If no lawsuit has ever been filed against Kaiser Aluminum & Chemical on behalf of the injured party, indicate in which state the claimant would have elected to file such suit: | State |
|---|---|
| | |

| Was a tolling agreement for the injured party ever in effect with respect to claim(s) against Kaiser Aluminum & Chemical? | Yes | No |
|---|---|---|

| If "yes", Date Tolling Agreement Began: | Date Tolling Agreement Ended: |
|---|---|
| | |

| Has an asbestos claim been filed on behalf of the injured party against Kaiser Aluminum & Chemical pursuant to an administrative settlement agreement? | Yes | No | |
|---|---|---|---|
| If "yes", Disease Claimed: | | | Date Filed (mm/dd/yyyy) |
| Has compensation been received for this claim?<br>(If "Yes", attach copy of release) | Yes | No | Payment Amount |

| Has a CTPV claim been filed on behalf of the injured party against Kaiser Aluminum & Chemical or the Kaiser CTPV PI Trust? | Yes | No | |
|---|---|---|---|
| If "yes", Disease Claimed: | | | Date Filed (mm/dd/yyyy) |
| Has compensation been received for this claim?<br>(If "Yes", attach copy of release) | Yes | No | Payment Amount |

| Has a silica claim been filed on behalf of the injured party against Kaiser Aluminum & Chemical or the Kaiser Silica PI Trust? | Yes | No | |
|---|---|---|---|
| If "yes", Disease Claimed: | | | Date Filed (mm/dd/yyyy) |
| Has compensation been received for this claim?<br>(If "Yes", attach copy of release) | Yes | No | Payment Amount |

## 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 | Country |
| 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 | Country |
| 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 | Country |
| 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: | | | | |

## 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 |
|---|---|---|---|
| | | | |

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)

☐ Full-time ☐ Part-time ☐ Retired ☐ Partially Disabled ☐ Fully Disabled ☐ N/A (Deceased)

| Amount of Last Annual Wages | Date of Last Wage Received (mm/dd/yyyy) |
|---|---|
| | |

## 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? | Birth Date (mm/dd/yyyy) | Financially Dependent? |
|---|---|---|---|
| | Yes No | | Yes 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? | Birth Date (mm/dd/yyyy) | Financially Dependent? |
|---|---|---|---|
| | Yes No | | Yes 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? | Birth Date (mm/dd/yyyy) | Financially Dependent? |
|---|---|---|---|
| | Yes No | | Yes 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? | Birth Date (mm/dd/yyyy) | Financially Dependent? |
|---|---|---|---|
| | Yes No | | Yes 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? | Birth Date (mm/dd/yyyy) | Financially Dependent? |
|---|---|---|---|
| | Yes No | | Yes No |

## 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 |
|---|---|
| | |

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
3967 Princeton Pike
Princeton, New Jersey 08540

## 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)