CASE MANAGEMENT ORDER

The Court finds that asbestos cases present complex litigation under Standard 3.10 of the Judicial Administration Standards and *California Rules of Court*, Rule 3.403(h). This Order shall comply with the *California Code of Civil Procedure* ("*CCP*"), the *California Rules of Court*, and Solano County Local Rules of Court unless specifically modified by the Court in recognition of the complex nature of this matter.

Asbestos cases require exceptional judicial management to avoid placing unnecessary burdens on the Court and litigants and to expedite the cases, keep costs reasonable, and promote effective decision-making by the Court, the plaintiffs/defendants and their counsel, within the meaning of *California Rules of Court*, Rule 3.400. As a result, it was and remains the policy of the Court to:

1. Promote the mutual expeditious exchange of necessary and relevant information to facilitate the prompt evaluation of cases whenever possible;

2. Curtail and prevent repetitive, burdensome discovery;

3. Encourage the delegation of some discovery tasks and the sharing of costs on common tasks to avoid unnecessary duplication and expense to the litigants; and

4. Bring asbestos cases cost effectively to early and meaningful settlement negotiations and resolution or trial where appropriate or to provide for sufficient discovery to allow for the timely filing and decision on dispositive motions.

I.
CASE MANAGEMENT

Prior to the scheduling of trial in any asbestos matter, plaintiff's counsel must provide to the Court and all parties a statement of compliance that plaintiff's complaint (1) conforms to the *California Rules of Court*, Rule 3.110 and (2) the service and appearance status of all named defendants. No trial date shall be set if the deposition of the exposed plaintiff has not been noticed and/or not completed as to all defendants who have been served unless there is good cause shown as to why plaintiff's deposition cannot be completed, prior to the trial setting conference.

Any party with an issue related to a trial setting conference and/or trial date that has not been resolved after meeting and conferring with opposing counsel may request that a Case Management Conference ("CMC") be scheduled. The requesting party shall file and serve a CMC statement setting forth the specific issue to be addressed by the Court with a meet and confer declaration as defined by *CCP* § 2016,040. Upon receipt of the CMC statement, the Court may set a CMC within fourteen ("14") days and provide notice to the requesting party providing no less than five ("5") court days notice of the CMC. Requesting party shall serve the notice of the CMC on all parties within one ("1") business day of the receipt of same from the Court.

II.
DISCLOSURE OF INFORMATION

The complex nature of asbestos eases allows this Court to direct methods or procedures regarding initial standard discovery among the parties in compliance with the Court's inherent powers under the *CCP*, *California Rules of Court*, and Solano Local Rules of Court. However, nothing in this section precludes a party from asserting its objections under applicable statutes and/or case law.

A. PRELIMINARY FACT SHEET

Contemporaneous with the filing of a complaint for alleged bodily injury due to asbestos exposure, there shall be filed a Preliminary Fact Sheet ("PFS") prepared and signed by plaintiffs' counsel. The PFS shall comply exactly with the form attached hereto. (*See* attached Exhibit A: Plaintiffs Preliminary Fact Sheet/New Filing/Asbestos Litigation.) The PFS, with required exhibits, shall accompany any service of summons and complaint thereafter made. The PFS is provided to defendants solely for information and administrative purpose and shall not be used by any part as evidence or for impeachment purposes, Plaintiffs shall serve DDC, in those cases in which they serve as Designated Defense Counsel, with a copy of the complaint, the PFS and exhibits contemporaneously with service on the first defendant.

B. **STANDARD DISCOVERY**

1. **DEFENDANTS' STANDARD DISCOVERY TO PLAINTIFF**

Within twenty-one ("21") days after entry of this order, plaintiff shall serve on all defendants responses to Standard Asbestos Case Interrogatories, Set 1. (*See* attached Exhibit B: Defendants' Standard Interrogatories to Plaintiff (Personal Injury), Set I.) Responses to Standard Loss of Consortium Interrogatories, Wrongful Death Interrogatories or Standard Friction Interrogatories, if appropriate, shall be served within thirty ("30") days after entry of this order. (*See* attached Exhibits C: Defendants' Standard Interrogatories to Plaintiff (Loss of Consortium), Set 1, Exhibit D: Defendants' Standard Interrogatories to Plaintiff (Wrongful Death), Set 1, Exhibit E: Defendants' Standard Interrogatories to Plaintiff (Friction), Set 1.) Plaintiff shall serve a response to the Standard Request for Production of Documents and Things (*see* attached Exhibit F: Defendants' Standard Request for Production and Identification of Documents and Things to Plaintiff(s)) and serve said responses on all defendants within thirty ("30") days after entry of this order or ten ("10") days prior to the date initially noticed for the deposition of plaintiff, whichever is earlier. If any defendant is subsequently served with the summons and complaint, plaintiff shall contemporaneously serve responses to the applicable Standard Interrogatories if said responses were previously served; otherwise such service will occur within twenty-one ("21") days of the initial service of the summons and complaint on any party. If any extension to these deadlines is requested, plaintiff must request extension from all of the served defendants in compliance with the *CCP*.

2. **PLAINTIFFS STANDARD DISCOVERY TO DEFENDANTS**

The Court will allow plaintiff to propound Plaintiffs Case-Specific Standard Interrogatories to Defendants (*see* Exhibit G: Plaintiffs Case-Specific Standard Interrogatories to Defendants). Following entry of this order, plaintiff may propound these interrogatories ten ("10") days after the service of the summons and complaint on, or appearance by, the defendant on whom they are served, whichever comes first.

III.
DESIGNATED DEFENSE COUNSEL

A. The California law firm of Berry & Berry is provisionally appointed under *Asbestos Claims Facility v. Berry & Berry* (1990) 219 Cal.App.3d 9 [267 Cal.Rptr. 896] as the Designated Defense Counsel ("DDC") for one ("1") year from the date of Order. Defendants shall select DDC and inform the Court of the identity of DDC on an annual basis from the date of this Order. If defendants do not identify a new DDC by the anniversary date, then the previously appointed DDC remains in place for another year. Until a further Order is issued by the Court, said DDC shall coordinate the procurement and scheduling of certain pretrial discovery activities described herein and, if requested by the Court, to report progress of the coordinated discovery to the Court. DDC shall not be deemed an attorney for any defendant solely as a result of said activities. Participating defendants do not waive the attorney-client privilege and/or disclosure of confidential attorney work product by DDC's performance of said activities.

B. Nothing herein precludes DDC from providing or contracting with any defendant for services beyond those authorized in this Order, Such services include, but are not limited to, jointly retaining experts on behalf of defendants, noticing, taking and/or defending medical expert witnesses at deposition, or acting as medical trial counsel provided that an association of attorneys has been filed, Any such additional services shall be charged only to defendants requesting or contracting with DDC for said additional services. However, by appearing at a deposition of a joint defense medical expert, or by requesting the work product from the expert's examination or review, that defendant will be billed and obligated to pay for its per capita share of the costs and tees associated with that expert examination or review, plus the costs and fees associated with acquisition of the materials upon which the expert relies. The amounts billed to such a defendant shall be credited per capita to each defendant which had previously paid or been billed for such services. To the extent any defendant requests an Independent Medical Examination ("IME") of plaintiff, DDC shall schedule and coordinate the IME which may, at defendants' option, include:

physical examination, chest radiographs/ CT scans, pulmonary function test and an oral history. DDC must comply with the standards set forth in *Asbestos Claims Facility v. Berry & Berry* (1990) 219 Cal.App.3d 9 [267 Cal.Rptr. 896] in executing its duties.

C. It is ordered that DDC shall have electronic access to all asbestos cases in which DDC has been appointed Designated Defense Counsel through the electronic service vendor.

D. DDC's costs and reasonable fees shall be shared equally among all defendants appearing in the action and allocated on a per capita basis for the following functions provided by DDC to all defendants:

1. As requested by the Court, provide reports or updates, or respond to Court inquiries, and/or attend Case Management Conferences, Trial Setting Conferences and Motions for Trial Preference;

2. Obtain authorizations and stipulations for the release of medical (including pathology and radiology), Medicare, employment, union and military records;

3. Notice, schedule and coordinate plaintiffs deposition with request for production of documents, including the cost of the court reporter, original transcript, videotaping, videoconferencing and may include plaintiffs reasonable travel expenses if taken at a more distant location as provided in *CCP* § 2025.250;

E. A defendant who is no longer an active party to a case shall provide written notice to DDC, and within one ("1") business day of receipt of same, DDC shall cease billing that defendant for any function pursuant to this Order.

F. No activity performed by DDC in this section shall constitute a general appearance by or on behalf of any defendant.

G. Nothing in this Order precludes a defendant from filing a motion to compel or other motion seeking relief and any such motion may be filed by DDC, at the request of a contracting defendant(s).

IV.
RECORD PROCUREMENT

A. Within ten ("10") days after receipt of the standard discovery responses, DDC shall forward authorization forms and stipulations (*see* attached Exhibits H-1 to H-16) necessary for production of records, pathology and radiology to plaintiff and plaintiff shall provide fully executed authorizations to DDC within thirty ("30") days of the receipt of the forms and stipulations. Duration of the executed authorizations shall be for one ("1") year. DDC may submit to plaintiff for signature and return to DDC within ten ("10") days, updated authorizations and/or any additional forms required by a particular facility where plaintiff/decedent received treatment.

B. Upon receipt of records obtained by stipulation or authorization, the document reproduction service will forward these records to plaintiffs' counsel and no sooner than twenty-one ("21") days later, the document reproduction service will provide copies to DDC, unless notified in writing of an objection. Any party may either make or oppose a motion to compel and/or a motion for protective order or without waiving the objection, make a motion *in limine* for disclosure of records at trial.

C. In cases where the complaint or preliminary fact sheet indicates an intent to file a Motion for Preference pursuant to *CCP* § 36 or in cases where said motion has been filed, the document reproduction service will immediately electronically scan and send (or hand deliver) copies of said records to plaintiff's counsel. The records will be provided to DDC no sooner than seven ("7") days after delivery of the records to plaintiffs' counsel unless DDC and the document reproduction service are advised in writing of an objection to said production. There shall be no "first look" as to plaintiffs Social Security Earnings Records.

D. All records produced pursuant to this section are presumed to be authenticated and to satisfy the business records exception of the hearsay rule under *Cal. Evid. Code* § 1270 to 1272 unless the party objecting to the admission establishes the contrary by a preponderance of the evidence.

E. DDC shall be responsible for initiating the procedures necessary to obtain plaintiffs medical and employment records and related medical evidence (radiographs, x-rays, photographs, pathology specimens, etc.), including issuance of subpoenas.

F. In those cases where a DDC is appointed, absent Court order, no other defendant shall initiate procedures to obtain from the plaintiff his/her medical and employment records or medical evidence. A defendant, however, may seek said records as part of a deposition subpoena or notice of depositions of plaintiffs employers or treating doctors.

G. DDC is appointed as primary custodian of pathology specimens and chest radiographs/CT scans which DDC obtains via subpoena or plaintiff s authorization/stipulation until the date of trial, at which time DDC shall deliver all pathology materials, films and CT scans to plaintiff. Upon written request DDC shall notify plaintiff of any pathology specimens and chest radiographs/CT scans obtained by DDC and cooperate with plaintiffs review of same. Plaintiff and those defendants participating in this function shall have reasonable and timely access to said materials.

V.
PATHOLOGY MATERIALS

The parties will cooperate in the provision and exchange of pathology materials and all parties shall have reasonable and timely access to said materials. With respect to the limited available pathology materials, there shall be no destructive testing, including any asbestos fiber burden analysis, without advanced written notice and agreement among the parties. If there is an agreement to conduct destructive testing, at least on-half (1/2) of the original material must be preserved. The pathology remaining after the parties have completed testing shall be returned to the medical facility from which it was obtained upon resolution of the case.

VI.
DEPOSITION OF PLAINTIFF

A. Plaintiff's deposition shall be noticed by DDC or by counsel for plaintiff pursuant to *CCP* § 2025.210, Prior to noticing the deposition of plaintiff, DDC and counsel for plaintiff

shall meet and confer regarding deposition dates and location. The party that notices the deposition shall proceed first.

B. Absent agreement of the parties or Court order, there is no presumptive time limit for the defense's examination of plaintiff. The Court may extend or shorten the length of the deposition upon a showing of good cause. The parties may, at any time, agree among themselves to extend or shorten the length of any deposition.

C. If plaintiff notifies defendants that preference under *CCP* § 36 will be or has been sought there is a presumptive twenty C20") hours for the defense's examination of plaintiff subject to adjustment by the Court for the number of active named defendants, number of alleged exposures, and number of job sites identified. The Court may extend or shorten the length of the deposition upon a showing of good cause. The parties may, at any time, agree among themselves to extend or shorten the length of any deposition.

D. If any portion of the trial preservation testimony is videotaped then the entirety of the plaintiffs testimony shall be videotaped. The costs of the videotaping of the plaintiff's testimony are the responsibility of the party noticing the videotaped testimony.

VII.
EXPERT DISCOVERY

By entry of this order, demand for exchange of expert witness information under *CCP* § 2034.210, *et seq., is* deemed served.

A. **TELEPHONIC DEPOSITIONS OF EXPERT WITNESSES PERMITTED**

Upon proper demand by a party (the deposing party) to depose a retained expert witness designated by another party (the defending party), the defending party may make the expert witness available for deposition by telephone upon the following conditions:

1. Counsel for the defending party shall notify all counsel at the time of disclosure that the expert witness will be offered for deposition by telephone. Any party objecting to the taking of the deposition by telephone shall advise all counsel in writing by facsimile, electronic service or hand delivery of the basis of their objection no later than five ("5") court days after the date of disclosure or three

("3") court days if preference under *CCP* § 36 has been granted. The parties are encouraged to give telephonic notice of their objection to the defending party. The defending party shall meet and confer in good faith with the opposing party to resolve any and all issues pertaining to the offered telephone deposition. If after meeting and conferring, an objection to the telephonic deposition persists, the offering/defending party seeking the telephonic deposition may make a motion to permit proceeding with a telephonic deposition. Said motion may be made upon one ("1") court day's notice and shall be heard by Judge Beeman,

2. The defending party will, at least two ("2") court days in advance of the deposition, also provide a full and complete copy of the expert's file (including but not limited to deposition(s) or medical records reviewed by the expert in preparation for his or her testimony which the expert has highlighted, tabbed or otherwise altered) and Curriculum Vitae to any party who so requests it.

3. If there are additions to the expert's file within two ("2") court days prior to the deposition, the defending party will provide all additional materials to any party who previously requested materials as soon as practicable, but at least one ("1") hour prior to the scheduled deposition, The defending party will notify the deposing party in writing two ("2") court days in advance of the deposition in the event the expert to be deposed does not have a file and/or Curriculum Vitae.

4. Counsel for the defending party shall be required to have a facsimile machine readily available or electronic mail access for use by the expert witness during the course of the deposition, and counsel for the deposing party shall be required to have a facsimile machine readily available or email access capable of transmitting attachments for use during the course of the deposition.

5. The attorney for any party may elect to be personally present with the deponent during the deposition, but in such case the deposition shall be taken, at the option of the expert witness, at the office of the expert witness or at such location as counsel for the electing party may designate within thirty-five ("35") miles of the office of

the expert witness. Any attorney so electing shall give notice of such election to the defending party by facsimile, electronic service or hand delivery within five ("5") days, or three ("3") days in cases in which preference has been granted, after notice has been provided of the date, time and place at which the expert is being offered by the defending party. Any party may attend by telephone from any other location. If counsel for the defending party elects to be personally present, notice shall be provided to all parties at the time the expert is offered for deposition. The defending party shall make arrangements to allow attorneys for any other party to attend the deposition by telephone.

6. The cost of the telephone connection shall be paid by the defending party and may be a recoverable cost of suit. The deposing party shall tender the expert's fee to the expert witness and/or counsel for the defending party no later than the scheduled time for the commencement of the deposition if the deposing party is present with the expert. If the deposing party is not present with the expert, the deposing party shall tender the expert's fee to the defending party no later than the scheduled time for the commencement of the deposition.

7. Nothing herein precludes the parties from reaching different or additional agreements concerning retained expert witness depositions. This Order does not apply to non-retained expert witness or percipient witness depositions which shall be taken pursuant to the applicable provisions of the *CCP* or by stipulation of the parties. Nothing in this Order shall limit a party's right to seek a protective order or other relief including a motion to exclude expert testimony and/or to compel the personal appearance of an expert for deposition and/or for sanctions pursuant to the applicable provisions of the *CCP*.

B. **CANCELLATION OF DEPOSITION**

Plaintiff and defendants shall cooperate in good faith to minimize late or untimely cancellations of expert witness depositions. Except as otherwise agreed, the parties shall provide a minimum of two ("2") court days' notification in the event of cancellation or change to a

scheduled expert witness deposition, When a cancellation is not timely made, the canceling party shall pay the expert witness his/ her fee for one hour of deposition time at the expert witness' standard deposition rate, This provision is intended to protect the schedules of expert witnesses and to adequately compensate them in the event of untimely cancellation.

VIII.
MANDATORY SETTLEMENT CONFERENCE

A. Mandatory Settlement Conferences ("MSC") may be scheduled with a judge of the Superior Court. The MSC ordinarily will take place between fourteen ("14") and thirty ("30") days before the initial trial date. Settlement conference statements are not required, however any party may elect to provide the court with a confidential settlement conference statement five ("5") court days prior to the scheduled conference. All settlement conference statements are confidential.

1. No later than ten ("10") days prior to the date set for the MSC, or as otherwise ordered by the Court, counsel for plaintiff shall provide to each remaining defendant a demand and identify all previously undisclosed, remaining defendants.
2. Plaintiff shall not be required to attend in person but must be available by phone.
3. Each defendant's principal, possessing final decision-making authority shall also be available by phone and is not required to attend in person.
4. Should the court deem it necessary, plaintiffs and/or defendants' principals shall be ordered to appear at MSCs in person.

B. Each party shall discuss at the MSC whether exposure on or after December 15, 1980 is alleged and/or otherwise at issue as to a defendant. Where exposure as to a defendant is generally or specifically alleged to have occurred on or after December 5, 1980, pursuant to the "Medicare Secondary Payer Act," 42 U.S.C. § 1395, *et seq.* (SMP) and any rules and regulations promulgated thereunder including the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173), the case shall be reported to Medicare should Plaintiff be Medicare eligible. Nothing in this paragraph precludes a defendant from reporting a settlement to Medicare.

C. Where a Plaintiff with exposure on or after December 5, 1980 alleged or otherwise at issue settles a claim and is a Medicare beneficiary at the time of settlement, no settlement is full, final and enforceable until the completed current Form B (Exh. H-15) is provided by Releasor(s) as to each Medicare eligible Plaintiff, decedent, and/or claimant unless otherwise agreed by the parties.

D. Where a Plaintiff is not Medicare eligible, he or she shall complete in advance of the MSC an Affidavit of Medicare Non-Eligibility similar to Exhibit, H-16. Should he or she become Medicare eligible or Medicare beneficiary after completing such form, he or she shall promptly notify all settling defendants.

IX.
AUTHORIZATION OF ELECTRONIC SERVICE

A. All attorneys who have appeared on behalf of their respective parties ("counsel of record") shall use LexisNexis File & Serve ("File & Serve") as the electronic service provider for service of all documents filed with the Court. Any party may personally serve documents filed with the court as an alternative method of service.

B. Within five (5) days of this Order, plaintiffs' counsel shall submit to File & ServeXpress via email to Sharif Soofi at: ssoofi@fileandservexpress.com or www.fileandservexpress.com, a complete and current service list of counsel of record or self-represented parties for this litigation. Within five (5) days of service of this Order, or within five (5) days of the entry of appearance for a new attorney of record or self-represented party, each attorney of record or self-represented party for this litigation shall register for electronic service by completing the registration located at the following website: www.fileandservexpress.com. Plaintiff shall promptly notify File & ServeXpress to remove any defendant from the service list who is no longer a party to this action

C. Plaintiff's Counsel shall be liaison counsel to LexisNexis for all service list changes. This Order shall apply only to the electronic service of documents upon counsel of record. Counsel or parties filing original documents with the Court shall do so manually with the

Clerk of the Court pursuant to the *California Code of Civil Procedure* and Solano County local rules.

D. Electronic service under this Order shall be construed by the Court and all parties to be equivalent to personal service. The two court days extension of time for electronic service under *California Code of Civil Procedure* section 1010.60)(4) does not apply. Any document for which service has not been completed by 5:00 pm is deemed served the following business day.

IT IS SO ORDERED.

Dated: SEP 18 2013

PAUL L. BEEMAN

HONORABLE PAUL BEEMAN, *Presiding Judge*
SOLANO COUNTY SUPERIOR COURT

EXHIBIT 14

"Consent to Release"
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on:

- **When to use a "consent to release" document vs. a "proof of representation" document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a "Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

MSPRC - NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:
(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other _____
(Explain)

Name of entity: _____

Contact for above entity: _____

Address: _____

_____

Telephone: _____

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.):

( ) One Year ( ) Two Years ( ) Other _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit www.mspre.info for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): _____

Date of Injury/Illness: _____

EXHIBIT 15

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Case Name:	Case Number:	17. State of Venue: (USPS Abbreviation)
Defendant Name:		

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare

Part A	Part B	Part C	Part D
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section A ALLEGED INJURED PARTY INFORMATION *(If living, provide address in Section G)*

4. Medicare Claim Number: (also known as HICN)			
5. Social Security Number:	6. Injured Party Last Name: (Please print name as it appears on Social Security card.)		
7. Injured Party First Name: (Please print name exactly as it appears on Social Security card.)	8. Injured Party Middle Name: (Please print name exactly as it appears on Social Security card.)		
9.Gender: ☐ Male ☐ Female	10. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):

Section B ALLEGED INCIDENT INFORMATION

12. CMS Date of Incident: Please state the date of the accident or date of first exposure, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

13. Industry Date of Incident: Please state the date of accident or date of last exposure, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

15. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes) optional field:

19. ICD-9 Diagnosis Code 1 (no decimal):

Provide valid ICD-9-CM Codes for any injury or illness you allege arose from the allegations made against settling defendant.

21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:

Description of Illness/Injury (Free Form Text Description):

Section C ALLEGED INJURED PARTY'S ATTORNEY or OTHER REPRESENTATIVE INFORMATION

84. Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

85. Claimant Representative Last Name:	86. Claimant Representative First Name:	87. Claimant Representative Firm Name:		
88. TIN/EIN, If Firm Entity; SSN. If Individual:	89-90. Representative Mailing Address:			
91. City:	92. State:	93-94. Zip Code +4:	95. Phone:	96. Ext. (If any):

OPTIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Section D If Section D Claimant has a representative other than Section C Representative, complete Section F

104. Claimant Relationship to Alleged Injured Party (please check one):
☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

105. TIN/EIN (Social Security, if Individuals):	*106. Claimant Last Name:*			
107. Claimant First Name:	*108. Claimant Middle Initial:*			
109. Claimant Entity/Organization Name:				
110. Mailing Address:				
112. City:	*113.State:*	*114. Zip Code+4:*	*116. Phone:*	*117. Ext. (if any):*

Section E SETTLEMENT INFORMATION

100. Date of Settlement:	101. Amount of Settlement:

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Section A-LOC	LOSS OF CONSORTIUM PLAINTIFF INFORMATION THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT PROVIDE ESTATE INFORMATION IN SECTION D

4-LOC. Medicare Claim Number: (also known as HICN)			
5-LOC. Social Security Number:	6-LOC. Last Name: (Please print name exactly as it appears on Social Security card.)		
7-LOC. First Name: (Please print name exactly as it appears on Social Security card.)	8-LOC. Middle Name: (Please print name/initial exactly as it appears on Social Security card.)		
9-LOC Gender: ☐ Male ☐ Female	10-LOC. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):
15-LOC. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes): (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 19-LOC)			
19-LOC. ICD-9 Diagnosis: (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)			

Signature of Attorney representing Plaintiff/Claimant(s) Date Printed Name

The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this form and that all information stated herein is well grounded in fact to the best of his/her knowledge, information and belief formed after reasonably inquiry.

*Numbers reflect claim input file field numbers, as set forth in Version 3.4 of the Official NGHP User Guide by CMS.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Case Name:	Case Number:
Defendant Name:	

Optional Section F — **CLAIMANT'S (found in Section D) ATTORNEY OR OTHER REPRESENTATIVE INFORMATION**

119. Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

120. Claimant Representative Last Name:	121. Claimant Representative First Name:	122. Claimant Representative Firm Name:
123. TIN/EIN, if Firm Entity; SSN. If Individual:	124. Representative Mailing Address:	

126. City:	127. State:	128. Zip Code +4:	129. Phone:	130. Ext. (if any):

Section G — **ALLEGED INJURED PARTY'S ADDRESS**

Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Optional Section D cont. — **ADDITIONAL CLAIMANT INFORMATION (Use only if Alleged Injured Party in Section A is deceased)**

Claimant Relation to Alleged Injured Party (please check one):
☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if Individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:
Claimant Entity/Organization Name:	
Mailing Address:	

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:
TIN/EIN, if Firm Entity; SSN. If Individual:	Representative Mailing Address:	

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section B cont. — **Additional ICD-9 fields, if necessary**

31. ICD-9 Diagnosis Code 7:	33.ICD-9 Diagnosis Code 8:	35 ICD-9 Diagnosis Code 9:	37.ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43.ICD-9 Diagnosis Code13:	45.ICD-9 Diagnosis Code 14:	47.ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:

51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:

If additional Section D Claimants exist, use page 3 and duplicate page, if necessary.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Field#	Field Name	Definition:
4	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Injured Party's Medicare Health Insurance Claim Number (if one has been issued).This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Injured Party's Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide last name of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
7	FIRST NAME	Provide first name of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
8	MIDDLE INITIAL	Provide middle initial of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITYCARD or Medicare Card if available.
9	GENDER	Indicate Alleged Injured Party's gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Injured Party's Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
12	CMS DATE OF INCIDENT	Provide Date of Incident (DOI). DOI as defined by CMS: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of FIRST exposure. For claims involving ingestion (for example, a recalled drug), it is the date of FIRST ingestion. For claims involving implants it is the date of the implant (or date of the first implant if there are multiple implants).
13	INDUSTRY DATE OF INCIDENT	Provide Industry Date of Incident (DOI) routinely used by the insurance/workers' compensation industry: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, or implantation, the date of incident is the date of LAST exposure, ingestion, or implantation.
15	OPTIONAL FIELD ALLEGED CUASE OF INJURY, ILLNESS OR INCIDENT	Claimant must provide either: 1) both a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code (Field 19) OR 2) the Description of Illness/Injury(Field 57). Claims submitted on or after 1/1/11, Claimant must provide both a valid Alleged Cause of Injury, Incident,or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code. (See notes above for Spouse Injury codes)
17	STATE OF VENUE	Provide the US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Use "US" where the claim is a Federal Tor Claims Act liability insurance matter or a Federal workers' compensation claim.
19-55	ICD-9 DIAGNOSIS CODE 1 - 19	(International Classification of Diseases, Ninth Revision, Clinical Modification) - Must be on the current list of valid codes accepted by CMS found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp At least one valid diagnostic code must NOT be on the list of insufficient codes (found in Appendix H to the NGHP User Guide, V. 2.0,and NOT an E or a V Code). (See notes above for Spouse injury codes)
57	RESERVED FOR FUTURE USE	Formerly used for the obsolete – Description of Illness / Injury
84	REPRESENTATIVE TYPE	Indicate the type of representative that the Alleged Injured Party has. Select from the options provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O= Other. If Alleged Injured Party has more than one representative, provide attorney information, if available.
85	REPRESENTATIVE LAST NAME	Provide Last Name of Representative.
86	REPRESENTATIVE FIRST NAME	Provide First Name of Representative.
87	REPRESETNATIVE FIRM NAME	Provide the Name of the Representative's Firm.
88	TIN/EIN, IF FIRM/ENTITY;SOCIAL SECURITY NUMBERIF INDIVIDUAL	Provide Alleged Injury Party's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
89	MAILING ADDRESS	Provide mailing address for the alleged injured party's representative named above.
91	CITY	Provide mailing address city for the alleged injured party's representative named above.
92	STATE	Provide mailing address state for the alleged injured party's representative named above
93	ZIP CODE +4	Provide mailing address zip code for the alleged injured party's representative named above. IncludeZip+4 code if known; if not known enter 0000.
95	PHONE	Provide telephone number of alleged injured party's representative.
96	PHONE EXTENSION, IF ANY	Provide telephone extension of alleged injured party's representative, if extension is available.
100	DATE OF SETTLEMENT	Date the Release is signed unless court approval is required - then it is the later of the date the Release is signed or thedate of court approval. If there is no written agreement, then it is the date of payment.
101	AMOUNT OF SETTLEMENT	Provide total amount of Settlement
104	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
105	TIN/EIN, IF ENTITY;SOCIAL SECURITY NUMBER,IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number(TIN)/Employer Identification Number (EIN) if claimant is an entity.
106	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
107	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
108	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
109	CLAIMANT	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

	ENTITY/ORGANIZATION NAME	Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
110	MAILING ADDRESS	Provide mailing address for claimant.
112	CITY	Provide mailing address city of the claimant.
113	STATE	Provide mailing address state of the claimant.
114	ZIP CODE+4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
116	PHONE	Provide telephone number of the claimant.
117	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
119	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of representative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored
120	CLAIMANT REPRESENTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
121	CLAIMANT REPRESENTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
122	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
123	TIN/EIN, IF FIRM/ENTITY; SOCIALSECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
124	CLAIMANT REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
126	CLAIMANT REPRESENTATIVE CITY	Provide mailing address city for the claimant's representative.
127	CLAIMANT REPRESENTATIVE STATE	Provide mailing address state for the claimant's representative.
128	CLAIMANT REPRESENTATIVE ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
130	CLAIMANT REPRESENTATIVE PHONE	Provide telephone extension of claimant's representative, if extension is available.
131	CLAIMANT REPRESENTATIVE PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

EXHIBIT 16

[NAME(S)], et al.	*	IN THE
Plaintiff(s)	*	[COURT]
v.	*	FOR
[NAME(S)], et al.	*	[LOCATION]
Defendant(s)	*	CASE NO.

* * * * * * * * * * *

AFFIDAVIT OF MEDICARE NON-ELIGIBILITY

1. I, [PLAINTIFF], am over the age of eighteen (18) and am competent to be a witness in this matter. I have personal knowledge of the facts set forth herein.

2. I understand that in reaching a settlement, the parties have considered Medicare's interest in recovering conditional payments made for medical treatment rendered as a result of the claim that is the subject of my above- captioned lawsuit.

3. I have provided my Social Security Number and date of birth. I understand that if I am a Medicare beneficiary and I do not provide the requested information, including a Health Insurance Claim Number, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claim(s) correctly and promptly.

4. I hereby make the following representations and warranties in affirming that I am not eligible for Medicare:

   (a) I have not applied for Medicare benefits.

   (b) Medicare has made no conditional payments for any medical expense or prescription expense related to the claimed injury.

   (c) I am not, nor have I ever been a Medicare beneficiary.

   (d) I am not currently receiving Social Security Disability Benefits.

   (e) I have not applied for Social Security Disability Benefits.

   (f) I have not been denied Social Security Disability Benefits.

   (g) I have not appealed from a denial of Social Security Disability Benefits.

   (h) I am not in End Stage Renal Failure.

(i) I have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease.

(j) No liens, including but not limited to liens for medical treatment of the claimed injury, by hospitals, physicians, or medical providers of any kind, have been filed for the treatment of injuries sustained as related to the above-captioned lawsuit.

5. I assume all responsibility for all liens related to the treatment of the claimed injury, including those asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date of Birth Social Security Number

_____ _____

Date [PLAINTIFF]

Sworn and subscribed before me this _____ day of_____, 20___

_____

Notary Public

_____

My Commission Expires:

Exhibit A

PRELIMINARY FACT SHEET

1. State the complete name and address of each person whose claimed exposure to asbestos is the basis of this lawsuit ("exposed person"):

2. Does plaintiff anticipate filing a motion for a preferential trial date within the next four months?

_____ Yes _____ No

3. Date of birth of each exposed person in item one and, if applicable, date of death:

_____ _____

_____ _____

Social Security Number of each exposed person:

_____ _____

_____ _____

4. Specify the nature or type of asbestos-related disease alleged by each exposed person.

_____ Asbestosis _____ Mesothelioma _____ Lung Cancer

_____ Other Cancer (specify) _____

_____ Pleural Thickening/Plaques _____ Other (specify) _____

5. For purposes of identifying the nature of exposure allegations involved in this action, please check one or more:

_____ Shipyard _____ Construction _____ Friction/Automotive

_____ Premises _____ Aerospace _____ Military

_____ Other (specify): _____

6. If applicable, indicate which exposure allegations apply to which exposed person.

_____

7. Identify each location alleged to be a source of an asbestos exposure, and to the extent known, provide the beginning and ending year(s) of each such exposure. Also specify each exposed person's employer and job title or job description during each period of exposure. (For example: "San Francisco Naval Shipyard, Pipefitter, 1939-1948"). Examples of locations of exposure might be a specific shipyard, a specific railroad maintenance yard, or perhaps more generalized descriptions such as "merchant marine" or "construction". If an exposed person

claims exposure during only a portion of a year, the answer should indicate that year as the beginning and ending year (e.g., 1947-1947).

Location of Exposure	Employer	Job Title at Time of Exposure	Year(s) of Exposure Beginning	Ending

(Attach Additional Pages, If Necessary)

8. For each exposed person who:

   a. worked in the United States or for a U.S. agency outside the territorial United States, attach to the copy of this fact sheet provided to Designated Defense Counsel a fully executed Social Security Earnings authorization (Exhibit H);

   b. may have had a Social Security disability award or is no longer employed and whose last employment was not with a United States government agency, attach to the copy of this fact sheet provided to Designated Defense Counsel a fully executed Social Security Disability authorization (Exhibit H);

   c. served at any time in the United States military, attach to the copy of this fact sheet provided to Designated Defense Counsel two fully executed originals of the stipulation (Exhibit H);

   d. was employed by the United States government in a civilian capacity, attach to the copy of this fact sheet provided to Designated Defense Counsel two fully executed originals of the stipulation (Exhibit H).

9. If there is a wrongful death claim, attach to the copy of this fact sheet provided to Designated Defense Counsel a copy of the death certificate, if available. If an autopsy report was done, also attach a copy of it to the copy of this fact sheet provided to Designated Defense Counsel.

By: _____
Attorney for Plaintiff

Exhibit B

PROPOUNDING PARTY: Defendants.
RESPONDING PARTY:
SET NUMBER: One

INTRODUCTION

Each plaintiff in the above-captioned asbestos litigation is required to respond to the following standard interrogatories separately and fully in writing, under oath, pursuant to Code of Civil Procedure Section 2030.010 *et seq.*. In responding to these standard interrogatories, YOU are required to furnish all information that is available to YOU or YOUR attorney(s). If YOU cannot answer a standard interrogatory completely, answer it to the fullest extent possible and specify the reason(s) for YOUR inability to respond fully.

DEFINITIONS

1. "AREA" means the name of the specific structure, building, building number, floor of the building, ship compartment, process line, unit, piece of equipment, or other specific place within the WORKSITE.

2. "ASBESTOSCONTAINING MATERIAL" means a material or product which consists of, or contains the mineral asbestos.

3. "CONTROL" means the act(s) of directing the manner and/or methods of conducting the work at a WORKSITE.

4. "DESCRIBE" as it relates to material means provide a complete description of the material including but not limited to: the material name, manufacturer, supplier, distributor, color, texture, consistency, shape, size and any markings; a description of the material's container including size, color and all writing on that container; and a description of how the material was used.

5. "DOCUMENTS" means any writing, as defined in Evidence Code Section 250 and includes the original or a copy of handwriting, typewriting, printing, photostating, photographing, computer printout, and every other means of recording upon any tangible thing or form of communication or representation including letters, words, pictures, sounds or symbols or combinations of them.

6. "IDENTIFY" as it relates to a DOCUMENT means provide the title of the DOCUMENT, the date the DOCUMENT was generated, the name of the author of the DOCUMENT, a description of the DOCUMENT (e.g., letter, memorandum, report, book, photograph, etc.) and any other information which would be required to specify the DOCUMENT in a request for production of DOCUMENTS issued pursuant to Code of Civil Procedure Section 2031.

7. "IDENTIFY" as it relates to an employer means to state the employer's name, address and telephone number.

8. "IDENTIFY" as it relates to a person means to provide the name, place of employment, job title, address and telephone number for each person.

9. "IDENTIFY" as it relates to a ship means to state the name of the ship, the owner of the ship, the operator of the ship, the type of ship, and the hull number of the ship.

10. "LOCATION" means the city, state, country, street address, intersection or shipyard. For work aboard ship, please IDENTIFY the ship and where it was located during the time YOU worked on board.

11. "OCCASION" refers to a day, any part of a day, or a series of day(s), week(s), month(s) or year(s) during which YOU worked continuously at a WORKSITE.

12. "RAW ASBESTOS" means asbestos fiber mined or milled, either packaged or in bulk, not compounded with other substances and essentially pure with the exception of naturally occurring trace amounts of other substances.

13. "RESPONSIBLE PARTY" means any person, business organization, or enterprise, including but not limited to the defendants in this action.

14. "SAFETY PRECAUTION" means respirators, masks, fans, air blowers, tarps, wetdown procedures, isolation and any other equipment and/or methods used to limit or prevent exposure to dust.

15. "WORKSITE" means any LOCATION where YOU worked at any time.

16. "YOU" and "YOUR" refer to the person who is named above as the responding party. If more than one responding party is named, "YOU" and "YOUR" refer to each responding party separately, not jointly.

INTERROGATORIES

1. Please state YOUR:

A. Full name including first, middle and last names;

B. Date of birth;

C. Age;

D. Place of birth;

E. Address;

F. Height and weight;

G. Social Security number;

H. Kaiser number;

I. Government Serial number;

J. Military Serial number;

K. Driver's license number and state;

L. All of the names by which YOU have been known;

M. Highest grade level of school completed;

N. Current spouse's name;

O. Spouse's date of birth;

P. Date of current marriage;

Q. Spouse's current address;

R. Spouse's occupation/employer;

S. Name(s) of any former spouse(s);

T. Date(s) of any former marriage(s); and

U. Place, date and circumstances under which any marriage(s) was (were) dissolved or terminated.

2. For each child (either natural or adopted) of any marriage, state:

A. Name;

B. Date of birth;

C. Whether natural or adopted;

D. Address;

E. Occupation; and

F. Whether the child is living or dead.

3. Are either of YOUR natural parents alive? If YOUR answer is "yes", please state for each parent:

A. Name of parent;

B. Current age;

C. Any history of cancer or respiratory disease; and

D. Occupation.

4. For each of YOUR blood relatives (for example: parent, grandparent, sibling, child, aunt, uncle) whom YOU believe died of either a malignancy (cancer) or pulmonary (lung) disease other than pneumonia, please state, separately for each person:

A. Full name;

B. Blood relation to YOU (for example: parent, grandparent, sibling, aunt, uncle);

C. Age at death;

D. Date of death;

E. City, county and state where the person died; and

F. The cause of death, as specifically described as possible;

G. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

5. State as completely as possible the address of each of YOUR residences during YOUR lifetime and the inclusive dates of each period of such residence.

6. State YOUR educational background and identify all institutions attended, including any apprenticeship courses, or formal onthejob training and identify all institutions attended, the date graduated from each institution, and YOUR major course of study and any special scholastic honors or degrees received.

7. State the earliest date that service of the summons and complaint was effected on any defendant in this case.

8. Have YOU ever been convicted of a felony? If "yes", please state fully and in detail the date, place and nature of each such felony conviction. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

9. Have YOU ever been a member of the Armed Forces? If "yes", please state: each branch of service in which YOU served; the inclusive dates of YOUR service; the date of YOUR discharge from active duty; YOUR service number; each place (e.g., fort, base, station, etc.) at which YOU served; and YOUR duties at each place. If YOU have not ever been a member of the Armed Forces due to health reasons, please state the health reasons.

10. For every doctor who has ever treated or examined YOU during the last 10 years for <u>any</u> condition, and beyond 10 years for cancer and/or conditions related to the lungs, respiratory system, and/or ribs and any additional complaints or conditions stated in response to Interrogatory No. 16, please state for each treatment or examination:

A. Doctor's name;

B. Doctor's address;

C. Treatment or examination received;

D. Date(s) of treatment or examination;

E. Reason for treatment or examination;

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks

containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

11. For every hospital in which YOU have ever been treated, tested, or examined whether as an "inpatient" or as an "outpatient" during the last 10 years for any condition and beyond 10 years for cancer and/or conditions related to the lungs, respiratory system, and/or ribs and any additional complaints or conditions stated in response to Interrogatory No. 16, please state for each hospital visit:

A. Name of hospital;

B. Address of hospital;

C. Test, treatment, examination or hospitalization received;

D. Date of test, treatment, examination or hospitalization received; and

E. Reason for hospital visit;

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

12. Have YOU had taken an Xray, CT scan or highresolution CT scan of YOUR "trunk"? If "yes", please state for each:

A. Name and address where taken;

B. Date(s) and number taken of each;

C. Part(s) of body xrayed or scanned;

D. Results, conclusions and/or diagnosis from each, except those prepared by consultants;

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

13. Have YOU ever undergone a pulmonary function test? If "yes", please state:

A. Name and address where test was performed;

B. Date of test;

C. Name of doctor administering and/or interpreting test;

D. Reason for test;

E. Results, conclusions and/or diagnosis from each test, except those prepared by consultants;

F. Were YOU informed of the results of the test?

G. Who informed YOU of the results of the test?

H. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

14. Describe the name and quantity of each type of drug, tranquilizer, sedative or other medication taken or used by YOU during the last 10 years, specifying the frequency and purpose of use.

15. Do YOU or YOUR attorney have any medical reports except those prepared by consultants from any persons, hospitals, doctors or medical practitioners or institutions that have ever treated or examined YOU at any time? If "yes", either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to YOUR answers to these interrogatories or (2) attach disks containing such data or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

16. Identify each and every complaint, symptom, adverse reaction or other injury which YOU allege is directly or indirectly related to YOUR alleged exposure to RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL and for each complaint, symptom, adverse reaction or other injury, please state:

A. The date on which YOU first became aware of signs of the complaint, symptom, adverse reaction or injury;

B. The date each such complaint, symptom, adverse reaction or injury ceased to affect YOU;

C. Any physical change in YOUR appearance occasioned by such complaint, symptom, adverse reaction or injury;

D. Each part of YOUR body which YOU contend has been affected;

E. The date upon which the complaint, symptom, adverse reaction or injury was reported to a doctor or physician;

F. State the name, address and telephone number of each such physician to whom said complaint, symptom, adverse reaction or injury was reported;

G. Whether YOU have lost any time from work as a result of YOUR asbestosrelated injury or medical condition;

H. If such injury has resulted in lost time from work, please state the date on which YOU first lost work and the amount of time lost from work; and

I. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

17. Have YOU been advised that YOU are suffering from an asbestos-related disease? If "yes", state:

A. The nature of the asbestos-related disease(s);

B. The date and time YOU were first advised;

C. The name, address, and telephone number of the physician and/or other persons who so informed YOU;

D. The name, address and telephone number of the physician who made the evaluation;

E. The method and information upon which such determination was based;

F. The name, address, and telephone number of any hospital, medical institution, laboratory, physician, nurse,

laboratory technician, etc., involved in any part of such determination;

G. The name, address, and telephone number of every person, including YOUR relatives, employer or anyone acting in YOUR behalf who was so advised. Please include the date when such persons were so advised;

H. IDENTIFY YOUR employer(s) at the time YOU were so advised;

I. The specific course(s) of treatment or therapy, including any medicine prescribed as a result of such determination and the name, address and telephone number of each prescribing physician;

J. State whether YOU have followed the medication or therapy regime prescribed by each of the said physicians for the treatment of said complaint, symptom, adverse reaction or injury; **K.** State the names and addresses of any other physicians or practitioners subsequently affirming or making the same determination; and

K. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

18. Have any of the said treating physicians informed YOU at any time that YOUR complaints, symptoms, adverse reactions or injuries may have been caused by factor(s) or reason(s) other than exposure to RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(S)? If "yes", please state:

A. The other factor(s) or reason(s) involved;

B. The names, addresses and telephone numbers of the physicians believing or suspecting such other factor(s) or reason(s) to be involved;

C. The date(s) that said physicians told YOU that they believed or suspected that other factor(s) or reason(s) might be involved;

D. The reason that said factor(s) or reason(s) were excluded as possible sources or causes of the symptoms; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

19. Please list all respiratory complaints and/or symptoms which YOU have suffered during the past 10 years and list the inclusive dates for each such complaint.

20. Have YOU ever had any biopsies or tissue samples taken during the past 10 years? If YOUR answer is "yes", state for each such procedure:

A. The name of the doctor performing such procedure;

B. The address where such procedure was performed;

C. The date when such procedure was performed;

D. The results, conclusions and/or diagnosis from such procedure; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

21. Do YOU know of any pathology slides that were made from any of YOUR tissue samples during the past 10 years? If YOUR answer is "yes", for each set of slides made please state:

A. The name of the hospital;

B. The name of the doctor;

C. The current location;

D. The date said slides were made; and

E. The accession number(s).

22. Have YOU ever suffered any personal injuries other than those involved in this lawsuit? If "yes", state for each such injury:

A. The date, place, names of persons involved, and circumstances surrounding such injury;

B. The nature and extent of the injuries including any ill effects or disabilities remaining at the time of the last treatment or examination;

C. The names, addresses and date(s) of last treatment or examination by all persons who treated or examined YOU in connection with such injury;

D. The nature and source of any disability benefits, pensions or other payments for such injuries; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

23. Have YOU ever smoked tobacco products of any type? If "yes", state:

A. The dates and time periods during which YOU have smoked;

B. The type of tobacco products YOU smoke or have smoked. Please state whether YOU inhaled the smoke or not;

C. The daily frequency with which YOU smoke or have smoked;

D. If YOU have ever smoked cigarettes, please state the average number of packs per day YOU smoked;

E. Please state the commercial brand name(s) of any tobacco products that YOU have used; and

F. Has any physician ever advised YOU to stop or curtail smoking tobacco products? If "yes", state:

1. The name of each such physician; and

2. The date(s) on which YOU were so advised.

24. Has any person with whom YOU have shared a household for more than one year been a regular user of cigarettes during the time you shared a household with the person? If "yes", state fully and in detail for each such person:

A. The name and relationship to YOU of the smoker;

B. The dates during which YOU shared a household with the person;

C. The brand name(s) of cigarettes the person used during the time YOU shared a household with the person and his/her frequency of use; and

D. The frequency with which the person smoked cigarettes in YOUR presence during the time YOU shared a household with the person.

25. Describe the extent to which YOU drank alcoholic beverages during YOUR lifetime, specifying the particular kind of alcoholic beverages and the quantity consumed per week over the period of time such beverages were consumed.

26. For every type of employment that you have ever had, whether self-employed or employed by others, please complete the following: (If more space is needed, please attach additional sheets containing the requested information.)

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
_____	_____	_____ - _____
_____	_____	_____ - _____
_____	_____	_____ - _____

Description of Job Duties:

_____

_____

Job Sites:

_____

_____

Your Estimate of Total Time (Days, Weeks, etc.) You Worked at That Site:

_____

_____

Do you claim exposure to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
_____	_____	____ - ____ __ __
_____	_____	____ - ____ __ __
_____	_____	____ - ____ __ __

Description of Job Duties:

_____

_____

Job Sites:

_____

_____

Your Estimate of Total Time (Days, Weeks, etc.) You Worked at That Site:

_____

_____

Do you claim exposure to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
_____	_____	____ - ____ __ __
_____	_____	____ - ____ __ __
_____	_____	____ - ____ __ __

Description of Job Duties:

Job Sites:

Your Estimate of Total Time (Days, Weeks, etc.) You Worked at That Site:

Do you claim exposure to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
		/ / - / /
		/ / - / /
		/ / - / /

Description of Job Duties:

Job Sites:

Your Estimate of Total Time (Days, Weeks, etc.) You Worked at That Site:

Do you claim exposure to asbestos at this employment? Yes _____ No _____

27. Are YOU or have YOU been a member of any labor union, including but not limited to the Heat, Frost, Insulation and Asbestos

Workers Union? If YOUR answer is "yes", state for each such union membership:

A. The name of each such international union and its number, along with the local number of each such union; and

B. The date and time periods during which YOU maintained membership in such union.

28. When did YOU first learn that exposure to asbestos was a potential health hazard?

29. Describe how YOU first became aware that exposure to asbestos was a potential health hazard.

30. When did YOU first observe anyone use any type of SAFETY PRECAUTION while working around RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(S)?

31. When, where and at whose direction did YOU first use any type of SAFETY PRECAUTION while working around RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(S)?

32. State whether any of YOUR employers have either required or made available physical examinations for their employees. If such physical examinations have either been required or made available to YOU, state for each of YOUR employers:

A. IDENTIFY YOUR employer;

B. The nature and extent of examinations;

C. The frequency of examinations;

D. Whether they were required or optional;

E. Whether xray examination was included;

F. The frequency, including specific dates and times, with which YOU submitted to such examinations;

G. Whether YOU received the results of any such examinations; the dates that they were given to YOU and the nature of the results;

H. The name, address and telephone number of the examining physician, nurse or technician;

I. YOUR detailed reasons for failing to submit to such examination when required or made available, if YOU did so fail to submit; and

J. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

33. If YOU are not currently employed, please state the last date worked and the reason that YOU are not currently employed.

34. Are YOU receiving any form of disability pension? If so, state:

A. From whom;

B. The amounts received each month; and

C. The anticipated duration of the disability.

35. Have YOU ever been discharged from or ever voluntarily left a position due to health problems? If "yes", state in detail the time, name of employer, place and circumstances. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

36. Were YOU ever exposed to RAW ASBESTOS or ASBESTOSCONTAINING MATERIALS(S) outside of YOUR work environment? If "yes", please state for each such OCCASION:

A. Circumstances surrounding the exposure;

B. Date(s) and LOCATION;

C. Duration and manner of the exposure; and

D. DESCRIBE the RAW ASBESTOS or ASBESTOS-CONTAINING MATERIAL(S).

37. State whether you assert a claim for loss of income and, if so, state fully and in detail the year and YOUR annual earnings for each of the last ten years in which YOU were employed.

38. Have YOU incurred any hospital expenses to date as a result of the injuries, complaints, etc. which YOU attribute to YOUR alleged exposure to asbestos? If "yes", state the total hospital expenses incurred and itemize each charge if more than one hospital is involved.

39. Have YOU incurred any medical expense (other than hospitalization) or have any medical expenses been incurred on YOUR behalf to date as a result of the injuries, complaints, etc. which YOU attribute to YOUR alleged exposure to asbestos? If "yes", state the total medical expenses incurred, itemizing each such charge.

40. Has any insurance company, union or any other person, firm or corporation paid for or reimbursed YOU for, or become obligated to pay for, any medical or hospital expenses incurred by the alleged exposure to asbestos? If "yes", state the name and address of the insurance company, union, person, firm or corporation who or which has paid or is obligated for the payment of or reimbursement for said expenses.

41. Have YOU ever at any time made a claim for or received for an asbestos-related condition any health or accident insurance benefits, Workers' Compensation payments, disability benefits, pension, accident compensation payment or veterans disability compensation? If "yes", state:

A. The illness, injury or injuries for which YOU made the claim;

B. The date when such injury or injuries were sustained, the place of occurrence and the nature of the accident or incident causing such injury;

C. The names and addresses of YOUR employer(s) at the time of each injury or illness;

D. The names and addresses of the examining doctors for each injury or illness;

E. The name of the board, tribunal or superior officer which or to whom the claim or claims were made or filed;

F. The date the claim was made or filed;

G. The claim, file or other number by which YOUR claim was identified;

H. The present status of such claims (pending settlement, dismissal, etc.);

I. The amounts of the benefits or awards or payments;

J. The dates covering the times during which YOU received the benefits or awards or payments;

K. The identity of the agencies or insurance companies from whom YOU received the awards, benefits or payments; and

L. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

42. Have YOU lost or do YOU claim any wage or earning loss as a result of YOUR alleged exposure to asbestos? If so, state:

A. How much time was lost from work or employment, listing the dates involved and the name and address of the employer;

B. The gross amount of salary or earnings which YOU received each pay day, stating the intervals of such paydays (e.g., weekly, bimonthly, monthly);

C. State the gross amount of salary or earnings actually lost due to the exposure;

D. If self-employed, state the total time lost from business, listing the dates involved and the gross financial loss to YOU, stating the nature of such loss and how incurred; and

E. Of the sum stated in YOUR response to subpart D of this interrogatory, state YOUR net loss.

43. Have YOU incurred any expense or financial loss including property damage, other than as listed above which YOU attribute in any degree to YOUR exposure to asbestos products? If so, state such

financial losses, expenses and property damage, giving the dates incurred and the amounts involved and the nature of each such expense or loss.

44. Has any insurance company, union or other person, firm or corporation paid for or reimbursed YOU for or become obligated to pay for or reimburse YOU or anyone on YOUR behalf for any sums of money (excluding medical or hospital expenses) to provide any of the following: disability or other benefits; loss of earnings; property damage resulting from the alleged exposure to asbestos? If "yes", state:

A. The nature of the obligation giving rise to the payment or reimbursement; and

B. The name and address of the insurance company, union or other person, firm or corporation who or which has paid for or is obligated for payment of or reimbursement for such sums of money.

45. Have you ever given a deposition or other testimony under oath? If so, state for each such deposition or testimony:

A. The date(s) it was given;

B. The name of the court or other body before which it was given; the identity of the proceeding including name, docket or other number, and venue or location;

C. The name, address and telephone number of the court reporter or other transcriber. If the proceeding was not transcribed, please so state;

D. Whether your or your attorney have a copy of the transcript; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

46. Have YOU ever had an application for life, health, accident, medical or hospital insurance rejected for health reasons? If "yes", state:

A. The date of the application(s);

B. The date of rejection(s);

C. The type of insurance for which YOU applied;

D. The identity of the insurance company with which each application was filed;

E. The reason for the rejection(s); and

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

47. Have YOU ever been a party to an action for damages for any personal injury YOU have suffered? If "yes", state:

A. The identity of all parties to the action(s) and their attorneys;

B. The court and place where each such action was filed and the date(s) of filing;

C. The nature and extent of the injuries claimed and whether any permanent disability remains;

D. The present status of each action and, if concluded, the final result thereof including the amount of any settlement or judgment.

48. Have YOU ever made any claim for personal injury, other than this lawsuit, for injuries which YOU claim are related to YOUR alleged exposure to asbestos? If "yes", please state:

A. The nature of such injury or injuries;

B. The date when such injury or injuries were sustained in each instance, the place of occurrence and the nature of the incident or accident causing this injury;

C. The names and addresses of all persons and companies to whom said claims were made;

D. The caption and case number;

E. The court filing including state and county;

F. The name and address of YOUR counsel of record;

G. The present status of such claims (pending settlement, dismissal, etc.).

49. Have YOU received any payments or reimbursements or have any payments been made on YOUR behalf from any source as a result of YOUR alleged exposure to asbestos, including without limitation settlements with defendants in this action, potential defendants, a bankrupt company, or any RESPONSIBLE PARTIES? If so, for each payment, please state:

A. The name of each person or company making said payment(s);

B. Total amount of payments from all sources; and

C. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

50. Do YOU have in YOUR possession or under YOUR control a Social Security office listing of past employers and dates of employment? If "yes", please either attach a copy or give the employer's name, address, date and quarterly Social Security Credit for each employer listed. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

51. Are YOU Medicare-eligible? If so, please state:

a. Whether you are currently enrolled in Medicare;

b. If you are not currently enrolled in Medicare, whether you have previously been enrolled;

c. The dates on which you are or were enrolled in Medicare;

d. YOUR Medicare number.

52. Has any person other than YOU received or sought treatment from Medicare for any reason related to your claims in this case? If so, please state, for each such person:

a. The name, address, and telephone number;

b. The person's relation to you (e.g. spouse, natural child);

c. The person's Medicare number;

d. The inclusive dates of such treatment.

53. Have YOU filed a claim against a bankruptcy trust? If "yes," state for each claim:

a. The name and address of that trust;

b. The date YOUR claim was filed;

c. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory to your answers to interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

Exhibit C

DEFENDANTS' STANDARD INTERROGATORIES TO PLAINTIFF LOSS OF CONSORTIUM
(Personal Injury)

PROPOUNDING PARTY: Defendants
RESPONDING PARTY:
SET NUMBER: One

Each plaintiff in the above-captioned asbestos litigation is required to respond to the following standard interrogatories separately and fully in writing, under oath, pursuant to Code of Civil Procedure section 2030.010 *et seq.* within 15 days of the filing of a complaint. In responding to these standard interrogatories, you are required to furnish all information that is available to you or your attorney(s). If you cannot answer a standard interrogatory completely, answer it to the fullest extent possible and specify the reason(s) for your inability to respond fully.

INTERROGATORIES

1. Please state:
   A. Your full name including first, middle and last names;
   B. Your address;
   C. Whether you currently reside with your spouse; and
   D. Your Social Security number.
2. Please state the date of your current marriage and the place of your current marriage.
3. Was your marriage ceremonial or common-law?
   A. If marriage was ceremonial, please state the name, address and official capacity of the person performing the marriage;
   B. If marriage was common-law, please outline the facts and circumstances relied upon to establish the marriage.
4. Did you and spouse have any natural or adopted offspring? If "yes", please state for each offspring:
   A. Full name including first, middle and last names;
   B. Address;

C. Date of birth; and

D. Whether natural or adopted.

5. Have you had any previous marriages? If "yes", please state:
   A. Previous spouse's name;
   B. Previous spouse's address;
   C. Dates of marriage;
   D. Names and ages of children, whether natural or adopted; and
   E. Place, date and circumstances under which marriage was dissolved or terminated.
6. Has your spouse had any previous marriages? If "yes", please state:
   A. Previous spouse's name;
   B. Previous spouse's address;
   C. Date of marriage;
   D. Names and ages of children, whether natural or adopted; and
   E. Place, date and circumstances under which marriage was dissolved or terminated.
7. On the average, how many hours per day did you regularly spend with your spouse prior to his/her current illness?
8. On the average, how many hours per day do you currently spend with your spouse?
9. What hobbies, sports, games, cultural, vocational and other interests did you share with or enjoy in common with your spouse prior to his/her illness?
10. Have you ever been legally separated from your spouse? If "yes", please state the circumstances, duration and dates of each such separation.
11. Have you ever been voluntarily separated from your spouse for reasons due to differences or disputes arising out of the

marital relationship? If "yes", please state the circumstances and duration of each such separation.

12. Within the last 10 years have you or your spouse ever filed a civil complaint with any governmental agency against the other for physical abuse? If "yes", please state:
    A. The person initiating the procedure;
    B. A description of the complaint, charge or grievance;
    C. The court or governmental body before which the proceeding was brought; and
    D. The disposition of the proceeding.
13. Within the last 10 years have you or your spouse ever filed a criminal complaint with any governmental agency against the other for physical abuse? If "yes", please state:
    A. The person initiating the procedure;
    B. A description of the complaint, charge or grievance;
    C. The court or governmental body before which the proceeding was brought; and
    D. The disposition of the proceedings.
14. Have you ever seen or consulted with any therapist or counselor or professional about sexual dysfunction or sexual incompatibility in your marriage? If "yes", please state the dates, the names of the parties seen and the circumstances of each such visit or consultation.
15. Please state the name, address and telephone number of every person who assisted you in any way in answering these interrogatories.
16. Either (1) attach all DOCUMENTS evidencing the information sought in these interrogatories and their subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

Exhibit D

DEFENDANTS' STANDARD INTERROGATORIES TO PLAINTIFF (Wrongful Death), Set 1

PROPOUNDING PARTY: Defendants.
RESPONDING PARTY:
SET NUMBER: One

INTRODUCTION

Each plaintiff in the above-captioned asbestos litigation is required to respond to the following standard interrogatories separately and fully in writing, under oath, pursuant to Code of Civil Procedure Section 2030.010 *et seq* within 15 days of the first service on any defendant. These interrogatories should be answered by the plaintiff most knowledgeable about the information sought regarding the decedent. In responding to these standard interrogatories, YOU are required to furnish all information that is available to YOU or YOUR attorney(s). If YOU cannot answer a standard interrogatory completely, answer it to the fullest extent possible and specify the reason(s) for YOUR inability to respond fully.

DEFINITIONS

1. "AREA" means the name of the specific structure, building, building number, floor of the building, ship compartment, process line, unit, piece of equipment, or other specific place within the WORKSITE.
2. "ASBESTOSCONTAINING MATERIAL" means a material or product which consists of, or contains the mineral asbestos.
3. "CONTROL" means the act(s) of directing the manner and/or methods of conducting the work at a WORKSITE.
4. "DECEDENT" means the deceased individual whose claimed asbestos exposure forms the basis of the allegations underlying this lawsuit.
5. "DESCRIBE" as it relates to material means provide a complete description of the material including but not limited to: the material name, manufacturer, supplier, distributor, color, texture, consistency, shape, size and any markings; a description of the material's container including size, color and all writing on that container; and a description of how the material was used.

6. "DOCUMENTS" means any writing as defined in Evidence Code Section 250 and includes the original or a copy of handwriting, typewriting, printing, photostating, photographing, computer printout, and every other means of recording upon any tangible thing or form of communication or representation including letters, words, pictures, sounds or symbols or combinations of them.
7. "IDENTIFY" as it relates to a DOCUMENT means provide the title of the DOCUMENT, the date the DOCUMENT was generated, the name of the author of the DOCUMENT, a description of the DOCUMENT (e.g., letter, memorandum, report, book, photograph, etc.) and any other information which would be required to specify the DOCUMENT in a request for production of DOCUMENTS issued pursuant to Code of Civil Procedure Section 2031.
8. "IDENTIFY" as it relates to an employer means to state the employer's name, address and telephone number.
9. "IDENTIFY" as it relates to a person means to provide the name, address and telephone number for each person.
10. "IDENTIFY" as it relates to a ship means to state the name of the ship, the owner of the ship, the operator of the ship, the type of ship, and the hull number of the ship.
11. "LOCATION" means the city, state, country, street address, intersection or shipyard. For work aboard ship, please IDENTIFY the ship and where it was located during the time DECEDENT worked on board.
12. "OCCASION" refers to a day, any part of a day, or a series of day(s), week(s), month(s) or year(s) during which DECEDENT worked continuously at a WORKSITE.
13. "RAW ASBESTOS" means asbestos fiber mined or milled, either packaged or in bulk, not compounded with other substances and essentially pure with the exception of naturally occurring trace amounts of other substances.

14. "RESPONSIBLE PARTY" means any person, business organization, or enterprise, including but not limited to the defendants in this action.
15. "SAFETY PRECAUTION" means respirators, masks, fans, air blowers, tarps, wetdown procedures, isolation and any other equipment and/or methods used to limit or prevent exposure to dust.
16. "WORKSITE" means any LOCATION where DECEDENT worked at any time.
17. "YOU" and "YOUR" refer to the person who is named above as the responding party. If more than one responding party is named, "YOU" and "YOUR" refer to each responding party separately, not jointly.

INTERROGATORIES

1. Please state YOUR:
   - A. Full name including first, middle and last names;
   - B. Relationship to the DECEDENT;
   - C. Date of birth;
   - D. Age;
   - E. Place of birth;
   - F. Address;
   - G. Height and weight;
   - H. Social Security Number;
   - I. Kaiser Number;
   - J. Government Serial Number;
   - K. Military Serial Number;
   - L. Driver's License Number and State;
   - M. All of the names by which YOU have been known;
   - N. Highest grade level completed;
   - O. Spouse's name;
   - P. Date of YOUR most recent marriage;
   - Q. Name of any former spouse;

3. Are either of the DECEDENT's natural parents alive? If your answer is "yes", please state for each parent:
    A. Name of parent;
    B. Current age;
    C. Any history of cancer or respiratory disease; and
    D. Occupation.
4. For each of DECEDENT'S blood relatives (for example: parent, grandparent, sibling, child, aunt, uncle) whom YOU believe died of either a malignancy (cancer) or pulmonary (lung) disease other than pneumonia, please state, separately for each person:
    A. Full name;
    B. Blood relation to DECEDENT (for example: parent, grandparent, sibling, aunt, uncle);
    C. Age at death;
    D. Date of death;
    E. Cause of death, as specifically described as possible;
    F. City, county and state where the person died; and
    G. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.
5. State as completely as possible the address of each of the DECEDENT's residences during his/her lifetime and the inclusive dates of each period of such residence.
6. Please state the DECEDENT's educational background and identify all institutions attended, including any apprenticeship courses or formal onthejob training, and identify all institutions attended, the date graduated from each institution, the major course of study and any special scholastic honors or degrees received.
7. State the earliest date that service of the summons and complaint was effected on any defendant in this case.

R. Date(s) of any former marriage(s); and

S. Place, date and circumstances under which any marriage(s) was (were) dissolved or terminated.

1B. Please state for the DECEDENT:

A. Full name including first, middle and last names;
B. Date of birth;
C. Place of birth;
D. Last residence address;
E. Height and weight;
F. Social Security Number;
G. Kaiser Number;
H. Government Serial Number;
I. Military Serial Number;
J. Driver's License Number and State;
K. All of the names by which the DECEDENT was known;
L. Highest grave level completed;
M. Spouse's name;
N. Spouse's date of birth;
O. Date of marriage;
P. Spouse's current address;
Q. Spouse's occupation/employer;
R. Name of any former spouse(s);
S. Date of any former marriage(s); and
T. Place, date and circumstances under which any marriage(s) was (were) dissolved or terminated.

2. For each child (either natural or adopted) of the DECEDENT, of any marriage, state:

A. Name;

B. Date of birth;

C. Whether natural or adopted;

D. Address;

E. Occupation; and

F. Whether the child is living or deceased..

8. Were either YOU or the DECEDENT ever convicted of a felony? If "yes", please state fully and in detail the date, place and nature of each such felony conviction and who was convicted.
9. Had the DECEDENT ever been a member of the Armed Forces? If "yes", please state: each branch of service in which the DECEDENT served; the inclusive dates of service; the date of discharge from active duty; the DECEDENT's service number; each place (e.g., fort, base, station, etc.) at which the DECEDENT served; and, duties at each place. If the DECEDENT was not a member of the Armed Forces due to health reasons, please state the health reason(s) why.
10. For every doctor who has ever treated or examined the DECEDENT during the last 10 years for <u>any</u> condition, and beyond 10 years for cancer and/or conditions related to the lungs, respiratory system, and/or ribs and any additional complaints or conditions stated in response to Interrogatory No. 16, please state for each treatment or examination:
    A. Doctor's name;
    B. Doctor's address;
    C. Treatment or examination received;
    D. Date(s) of treatment or examination;
    E. Reason for treatment or examination; and
    F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.
11. For every hospital in which the DECEDENT had ever been treated, tested or examined whether as an "inpatient" or as an "outpatient" during the last 10 years for <u>any</u> condition, and beyond 10 years for cancer and/or conditions related to the lungs, respiratory system, and/or ribs and any additional complaints or conditions stated in response to Interrogatory No. 16, please state for each hospital visit:

A. Name of hospital;

B. Address of hospital;

C. Test, treatment, examination or hospitalization received;

D. Date of test, treatment, examination or hospitalization received;

E. Reason for hospital visit; and

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

12. Did DECEDENT ever have an xray, CT scan or highresolution CT scan taken of his/her trunk? If "yes", please state for each:

A. Name and address where taken;

B. Date(s) and number taken of each;

C. Part(s) of body xrayed or scanned;

D. Results, conclusions and/or diagnosis from each, except those prepared by consultants; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

13. Had the DECEDENT ever undergone a pulmonary function test? If "yes", please state the following:

A. Name and address where test was performed;

B. Date of test;

C. Name of doctor administering and/or interpreting test;

D. Reason for test;

E. Results, conclusions and/or diagnosis from each test, except those prepared by consultants;

F. Was the DECEDENT informed of the results of the test?

G. Who informed the DECEDENT of the results of the test?

H. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

14. Describe the name and quantity of each type of drug, tranquilizer, sedative, or other medication taken or used by the DECEDENT during the last 10 years of the DECEDENT's life, specifying the frequency and purpose of use.

15. Do YOU or YOUR attorney have any medical reports except those prepared by consultants from any persons, hospitals, doctors, or medical practitioners or institutions that ever treated or examined the DECEDENT at any time? If "yes", either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents. If YOU will not voluntarily attach copies of reports to the answers to these interrogatories, then please state fully and in detail for each:

A. The identity of the report(s) by date, subject matter, name, address, job title or capacity of the persons to whom it is addressed or directed and the job title or capacity of the person or persons who prepared the same; and

B. The name, address and present whereabouts of the person who has present custody or control thereof and the purpose of said preparation.

16. Identify each and every complaint, symptom, adverse reaction or other injury which YOU allege is directly or indirectly related to DECEDENT's alleged exposure to RAW ASBESTOS or

ASBESTOSCONTAINING MATERIAL(S), and for each complaint, symptom, adverse reaction, or other injury, please state:

A. The date on which the DECEDENT first became aware of the signs of the complaint, symptom, adverse reaction or injury;

B. The date each such complaint, symptom, adverse reaction or injury ceased to affect the DECEDENT;

C. Any physical change in the DECEDENT's appearance occasioned by such complaint, symptom, adverse reaction or injury;

D. Each part of the DECEDENT's body which YOU contend was affected;

E. The date upon which the complaint, symptom, adverse reaction or injury was reported to a doctor or physician;

F. State the name, address and telephone number of each such physician to whom said complaint, symptom, adverse reaction or injury was reported;

G. State whether the DECEDENT lost any time from work as a result of the DECEDENT's asbestosrelated injury or medical condition;

H. If such injury resulted in lost time from work, please state the date on which the DECEDENT first lost work and the amount of time lost from work; and

I. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

17. Please state when it was first determined that the DECEDENT was suffering from an asbestosrelated disease. Please include in YOUR answer:

A. The nature of the asbestosrelated disease(s);

B. The date and time of such determination;

C. When and by what means that determination was first communicated to each plaintiff herein;

D. The name, address and telephone number of the physician and/or other person(s) who so informed you;

E. The method and information upon which such determination was based;

F. The name, address and telephone number of any hospital, medical institution, laboratory, physician, nurse, laboratory technician, etc., involved in any part of such determination;

G. The name, address and telephone number of every person, including the DECEDENT's relatives, employer, or anyone acting in the DECEDENT's behalf, to whom such determination was made known. Please include the date, time and place of such revelation, and the name, address and telephone number of anyone witnessing said revelation;

H. The name, address and telephone number of the DECEDENT's employer(s) at the time of such determination;

I. The specific course(s) of treatment or therapy, including any medicine prescribed as a result of such determination, and the name, address and telephone number of each prescribing physician;

J. State whether the DECEDENT followed the medication or therapy regime prescribed by each of the said physicians for the treatment of said complaint, symptom, adverse reaction or injury;

K. Please state the names and addresses of any other physicians or practitioners subsequently affirming or making the same determination; and

L. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

18. Did any of the said treating physicians inform either YOU, any plaintiff or the DECEDENT at any time that the complaints, symptoms, adverse reactions or injuries may have been caused by factor(s) or reason(s) other than exposure to RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(s)? If "yes", please state:

A. The other factor(s) or reason(s) involved;

B. The names, addresses and telephone numbers of the physicians believing or suspecting such other factor(s) or reason(s) to be involved;

C. The date(s) that said physicians told either YOU, any plaintiff or the DECEDENT that they believed or suspected that other factor(s) or reason(s) might be involved and to whom that information was provided on each such date;

D. The reason that said factor(s) or reason(s) were excluded as possible sources or causes of the symptoms; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

19. Was a death certificate prepared after the death of the DECEDENT? If "yes", please state:

A. Whether it was filed;

B. The office in which it was filed;

C. The address and occupation of the person listed on the certificate as the informant;

D. The relationship to or connection with DECEDENT of the person listed as the informant;

E. The name, address and specialty of each doctor furnishing information appearing on the death certificate;

F. The immediate cause of death shown on the death certificate and, if known, any contributing causes listed; and

G. The exact time, date and place of death shown on the death certificate.

20. Was an autopsy performed on the body of the DECEDENT? If "yes", for each autopsy state:

A. The name, address and official capacity of each person authorizing or ordering the autopsy;

B. The relationship to or connection with DECEDENT of each person authorizing or ordering the autopsy;

C. Why the autopsy was ordered;

D. Whether the autopsy involved the DECEDENT's entire body and, if not, to which organ(s) it was confined.

E. The name, address, occupation and professional specialty of each person performing the autopsy;

F. The name, address, occupation and professional specialty of any person or organization which in addition to that identified in subpart 19(E) also had custody of DECEDENT's body or any portion thereof in furtherance of obtaining the autopsy or any portion of an autopsy;

G. The time and date the autopsy and/or any limited autopsy was performed;

H. The cause of death shown by the autopsy;

I. The name, address and occupation of each person having custody of the report of the results of the autopsy;

J. Whether YOU have or can obtain a copy of the autopsy report or if YOU will do so without a Motion to Produce and attach a copy of each autopsy report to YOUR answers to these interrogatories; and

K. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

21. Do YOU know of any pathology slides that were made of any tissue samples of the DECEDENT during the last 10 years of

DECEDENT'S life? If YOUR answer is "yes", for each set of slides made please state:

A. The name of the hospital;

B. The name of the doctor;

C. The current location;

D. The date said slides were made;

E. The accession number(s); and

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

22. Had the DECEDENT ever suffered any personal injuries other than those involved in this lawsuit? If "yes", state for each such injury:

A. The date, place, names of persons involved, and circumstances surrounding such injury;

B. The nature and extent of the injuries including any ill effects or disabilities remaining at the time of the last treatment or examination;

C. The nature and extent of the injuries including all ill effects or disabilities remaining at the time of death of DECEDENT;

D. The names, addresses and date(s) of last treatment or examination by all persons who treated or examined DECEDENT in connection with such injury;

E. The nature and source of any disability benefits, pensions or other payments for such injuries; and

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS

with sufficient particularity that they may be made the subject of a request for production of documents.

23. Did the DECEDENT ever smoke tobacco products of any type? If "yes", please state:

A. The dates and time periods during which the DECEDENT smoked;

B. The type of tobacco products the DECEDENT smoked and whether the DECEDENT inhaled the smoke or not;

C. The daily frequency with which the DECEDENT smoked;

D. If the DECEDENT ever smoked cigarettes, state the average number of packs per day so consumed;

E. The commercial brand name(s) of any tobacco products that the DECEDENT used; and

F. Whether any physician ever advised DECEDENT to stop or curtail smoking tobacco products? If "yes", please state:

1. The name of each such physician; and
2. The date(s) on which DECEDENT was so advised

24. Was any person with whom the DECEDENT shared a household for more than one year a regular user of cigarettes during the time DECEDENT shared a household with that individual(s)? If "yes", please state fully and in detail for each such person:

A. The name and relationship to the DECEDENT of the smoker;

B. The dates during which the DECEDENT shared a household with that person;

C. The brand name(s) of cigarettes the person used during the time DECEDENT shared a household; and

D. The frequency with which that person smoked cigarettes in the DECEDENT's presence during the time the DECEDENT shared a household.

25. Describe the extent to which the DECEDENT drank alcoholic beverages during the DECEDENT's lifetime, specifying the particular kind of alcoholic beverages and the quantity consumed

per week over the period of time such beverage(s) were consumed.

26. For every type of employment that DECEDENT had ever had, whether self employed or employed by others, please complete the following: (If more space is needed, please attach additional sheets containing the requested information.) Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your anwers to these interrogatories, or (2) attach disks containing such data; or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
		_____ - _____
		_____ - _____
		_____ - _____

Description of Job Duties:

_____

Job Sites:

_____

Your Estimate of Total Time (Days, Weeks, etc.) Decedent Worked at That Site:

_____

Do you claim Decedent was exposed to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
		_____ - _____

_____	_____	_____ –	_____ –
_____	_____	_____ –	_____ –

Description of Job Duties:

_____

_____

Job Sites:

_____

_____

Your Estimate of Total Time (Days, Weeks, etc.) Decedent Worked at That Site:

_____

_____

Do you claim Decedent was exposed to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)	
_____	_____	_____ –	_____ –
_____	_____	_____ –	_____ –
_____	_____	_____ –	_____ –

Description of Job Duties:

_____

_____

Job Sites:

_____

_____

Your Estimate of Total Time (Days, Weeks, etc.) Decedent Worked at That Site:

_____

_____

Do you claim Decedent was exposed to asbestos at this employment? Yes _____ No _____

Employer's Name and Address	Job Title	Date Started - Date Ended (Month, Day, Year)
		___ - ___
		___ - ___
		___ - ___

Description of Job Duties:

_____

Job Sites:

_____

Your Estimate of Total Time (Days, Weeks, etc.) Decedent Worked at That Site:

_____

Do you claim Decedent was exposed to asbestos at this employment? Yes _____ No _____

27. Was the DECEDENT ever a member of any labor union, including but not limited to the Heat, Frost, Insulation and Asbestos Workers Union? If "yes", please state for each such union membership:

    A. The name of each such international union and its number, along with the local number of each such union; and

    B. The date and time periods during which the DECEDENT maintained membership in such union.

28. When and how did the DECEDENT first learn that exposure to asbestos was a potential health hazard?

29. When did the DECEDENT first observe anyone use any type of SAFETY PRECAUTION while working around RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(s)?

30. When, where and at whose direction did the DECEDENT first use any type of SAFETY PRECAUTION while working around RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(s)?

31. Please state whether any of the DECEDENT's employers either required or made available physical examinations for their employees. If such physical examinations were either required or made available to the DECEDENT, please state for each such employer:

A. The employer;

B. The nature and extent of examinations;

C. The frequency of examinations;

D. Whether they were required or optional;

E. Whether xray examination was included;

F. The frequency, including specific dates and times with which the DECEDENT submitted to such examinations;

G. Whether the DECEDENT received the results of any such examinations; the dates that they were given to the DECEDENT and the nature of the results;

H. The name, address and telephone number of the examining physician, nurse or technician;

I. The DECEDENT's detailed reasons for failing to submit to such examination when required or made available, if the DECEDENT did so fail to submit; and

J. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

32. Was the DECEDENT ever exposed to RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(S) outside of the

DECEDENT'S work environment? If "yes", please state for each such OCCASION:

A. The circumstances surrounding the exposure;

B. The date(s) and LOCATION;

C. The duration and manner of the exposure; and

D. DESCRIBE the RAW ASBESTOS or ASBESTOSCONTAINING MATERIAL(S).

33. Was the DECEDENT ever discharged from or did the DECEDENT ever voluntarily leave a position due to health problems? If "yes", please state in detail the time, name of employer, place and circumstances and either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents..

34. If the DECEDENT was not employed at the time of death, please state the DECEDENT's last date worked and the reason that the DECEDENT was not employed thereafter.

35. Was the DECEDENT receiving any form of disability pension at the time of death? If "yes", please state:

A. From whom;

B. The amounts received each month; and

C. The anticipated duration of the disability pension.

36. If you state a claim for loss of DECEDENT'S income, state fully and in detail the year and the DECEDENT's annual earnings for each of the last 10 years in which the DECEDENT was employed.

37. Did the DECEDENT, during the last 10 years of DECEDENT's life, engage in any other activity or participate in any way in any business designed to produce income not mentioned in the preceding interrogatories? If "yes", for each such activity or business state:

A. A description of the activity or business;

B. The amount of time DECEDENT devoted to the activity or business during each of the last ten years of DECEDENT's life; and

C. The amount of income received from the activity of business for each of the last ten years of DECEDENT's life.

38. At the time of death, had the DECEDENT incurred any hospital expenses as a result of the injuries, complaints, etc. which YOU attribute to the DECEDENT's alleged exposure to asbestos? If "yes", please state the total hospital expenses incurred and itemize each charge if more than one hospital is involved.

39. At the time of death, had the DECEDENT incurred any medical expense (other than hospitalization) or had any medical expenses been incurred on the DECEDENT's behalf to date as a result of the injuries, complaints, etc. which YOU attribute to the DECEDENT's alleged exposure to asbestos? If "yes", please state the total medical expenses incurred, itemizing each such charge.

40. Has any insurance company, union or any other person, firm or corporation paid for or reimbursed, or become obligated to pay for, any medical or hospital expenses incurred by the DECEDENT as a result of the alleged exposure to asbestos? If "yes", please state the name and address of the insurance company, union, person, firm or corporation who or which has paid or is obligated for the payment of or reimbursement for said expenses.

41. Had the DECEDENT ever given a deposition or other testimony under oath? If so, please state for each such deposition or testimony:

A. The date(s) it was given;

B. The name of the court or other body before which it was given; the identity of the proceeding including name, docket or other number, and venue or location;

C. The name, address and telephone number of the court reporter or other transcriber. If the proceeding was not transcribed, please so state;

D. Whether YOU or YOUR attorney have a copy of the transcript; and

E. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

42. Had the DECEDENT ever at any time made a claim for or received for an asbestosrelated condition any health or accident insurance benefits, Workers' Compensation payments, disability benefits, pension, accident compensation payment or veterans disability compensation? If "yes", please state:

A. The illness, injury or injuries for which the DECEDENT made the claim;

B. The date when such injury or injuries were sustained, the place of occurrence and the nature of the accident or incident causing such injury;

C. The names and addresses of the DECEDENT's employer(s) at the time of each injury or illness;

D. The names and addresses of the examining doctors for each injury or illness;

E. The name of the board, tribunal or superior officer which or to whom the claim or claims were made or filed;

F. The date the claim was made or filed;

G. The claim, file or other number by which the DECEDENT's claim was identified;

H. The present status of such claims (pending settlement, dismissal, etc.);

I. The amounts of the benefits or awards or payments;

J. The dates covering the times during which the DECEDENT received the benefits or awards or payments;

K. The identity of the agencies or insurance companies from whom the DECEDENT received the awards, benefits or payments; and

L. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

43. Had the DECEDENT ever had an application for life, health, accident, medical or hospital insurance rejected for health reasons? If "yes", please state:

A. The date of the application(s);

B. The date of rejection(s);

C. The type of insurance for which the DECEDENT applied;

D. The identity of the insurance company with which each application was filed;

E. The reason for the rejection(s); and

F. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

44. Had the DECEDENT ever been a party to an action for damages for any personal injury the DECEDENT suffered? If "yes", please state:

A. The identity of all parties to the action(s) and their attorneys;

B. The court and place where each such action was filed and the date(s) of filing;

C. The nature and extent of the injuries claimed and whether any permanent disability remained at the time DECEDENT died; and

D. The present status of each action and, if concluded, the final result thereof including the amount of any settlement or judgment.

45. Had the DECEDENT ever made any claim for personal injury, other than this lawsuit, for injuries which YOU claim are related to the DECEDENT's alleged exposure to asbestos? If "yes", please state:

A. The nature of such injury or injuries;

B. The date when such injury or injuries were sustained in each instance, the place of occurrence and the nature of the incident or accident causing this injury;

C. The names and addresses of all persons and companies to whom said claims were made;

D. The caption and case number;

E. The court filing including state and county;

F. The name and address of YOUR counsel of record;

G. The present status of such claims (pending settlement, dismissal, etc.); and

H. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory and its subparts to your answers to these interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

46. Had the DECEDENT received any payments or reimbursement or have any payments been made on the DECEDENT's behalf from any source as a result of the DECEDENT's alleged exposure to asbestos, including without limitation settlements with defendants in this action, potential defendants, a bankrupt company, or any RESPONSIBLE PARTIES? If "yes", for each payment please state:

A. The name of the each person or company making said payment(s); and

B. Total amount of payments from all sources.

47. Do YOU have in YOUR possession or under YOUR control a Social Security office listing of all the DECEDENT's past employers and dates of employment? If "yes", please either attach a copy or give the employer's name, address, date and quarterly Social Security Credit for each employer listed.

48. Are YOU Medicare-eligible? If so, please state:

a. Whether you are currently enrolled in Medicare;

b. If you are not currently enrolled in Medicare, whether you have previously been enrolled;

c. The dates on which you are or were enrolled in Medicare;

d. YOUR Medicare number.

49. Has any person other than YOU received or sought treatment from Medicare for any reason related to your claims in this case? If so, please state, for each such person:

a. The name, address, and telephone number;

b. The person's relation to you (e.g. spouse, natural child);

c. The person's Medicare number;

d. The inclusive dates of such treatment.

50. Have YOU filed a claim against a bankruptcy trust? If "yes," state for each claim:

a. The name and address of that trust;

b. The date YOUR claim was filed;

c. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory to your answers to interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

Exhibit E

DEFENDANTS' STANDARD INTERROGATORIES TO PLAINTIFF (FRICTION)

INTRODUCTION

Each plaintiff in any asbestos case involving allegations of exposure to friction products is required to answer the following standard interrogatories separately and fully in writing, under oath, pursuant to Code of Civil Procedure section 2030 by the earlier of at least 30 days prior to the date initially noticed by Designated Defense Counsel for the deposition of the plaintiff; of, in the event the plaintiff's deposition is noticed by plaintiff, contemporaneous with service of the deposition notice. In responding to these standard interrogatories, YOU are required to furnish all information that is available to YOU or YOUR attorney(s). If YOU cannot answer an interrogatory completely, answer it to the fullest extent possible and specify the reason(s) YOU are unable to respond fully.

DEFINITIONS

1. "ASBESTOS-CONTAINING FRICTION PRODUCTS" means "BRAKE LININGS" as defined below and MOTOR VEHICLE transmission parts such as clutches, clutch plates, clutch discs, clutch facings and linings, or any other MOTOR VEHICLE parts which contain or have parts made from asbestos.
2. "BRAKE LININGS" mean the metallic shoe and friction material attached thereto as well as disc brake pads and calipers.
3. "CONTAINER" means any package, cart, box, wrapping, bag or other material in which the ASBESTOS-CONTAINING FRICTION PRODUCTS came.
4. "FRICTION MATERIAL DEFENDANTS" means those defendants who plaintiff(s) has/have named in the complaint and who plaintiff(s) allege(s) are in the business of selling, manufacturing or distributing ASBESTOS-CONTAINING FRICTION PRODUCTS and/or any other MOTOR VEHICLE parts which plaintiff(s) allege(s) contain asbestos.
5. "IDENTIFY" as used in reference to documents means to give such specific descriptive information about each document with sufficient particularity as would enable plaintiff to respond to a request to produce such document.
6. "IDENTIFY" as used in reference to any individual or entity means to state their name, address, telephone number and, if

appropriate, his/her employer, employer's address and relationship to plaintiff (coworker, friend, relative, etc.).

7. "MOTOR VEHICLE" means any motor vehicle or mobile equipment and their systems or parts, including but not limited to a car, truck, tractor, trailer, bus or heavy motorized equipment upon which plaintiff claims he/she performed any repairs or work that resulted in an exposure to asbestos.
8. "WRITTEN INFORMATION" means any printing, writing, labeling, logos, imprints or stamps which might appear on ASBESTOS-CONTAINING FRICTION PRODUCTS or CONTAINERS.
9. "YOU" or "YOUR" in a personal injury case means the plaintiff. In a wrongful death case, they mean the decedent.

INTERROGATORIES

1. State the full name of each plaintiff answering these interrogatories.
2. Do YOU contend that YOU were exposed to asbestos from any ASBESTOS-CONTAINING FRICTION PRODUCTS at any place of employment? If so:
   A. State the names and address of all places of employment where YOU contend such an exposure took place.
   B. State the dates YOU worked at each place of employment;
   C. IDENTIFY YOUR immediate supervisor(s) at each place of employment;
   D. IDENTIFY all of YOUR coworkers at each place of employment (whose name YOU recall or whose identity is known to YOUR attorney);
   E. IDENTIFY any other person with knowledge of YOUR alleged exposure at each place of employment;
   F. State YOUR job title at each place of employment;
   G. State YOUR job responsibilities at each place of employment;

H. Provide a complete description of any work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by YOU which YOU contend caused an asbestos exposure to YOU at each place of employment.

I. State the specific parts or components YOU worked with which YOU contend were ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment;

J. State the frequency of YOUR exposure to each specific ASBESTOS-CONTAINING FRICTION PRODUCT at each place of employment;

K. For brake replacements, describe the method used to clean the brake assembly at each place of employment, including the tools and equipment used;

L. For clutch replacements, describe the method used to clean the clutch assembly at each place of employment, including the tools and equipment used;

M. IDENTIFY by manufacturer and type each replacement ASBESTOS-CONTAINING FRICTION PRODUCT installed by YOU by manufacturer and type (e.g., brake linings by ABC Corp. and XYZ Corp.);

N. State whether YOU did any arcing of ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment and, if so, the frequency of this activity;

O. State whether YOU did any grinding of ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment and, if so, the frequency of this activity;

P. State whether YOU did any sanding of ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment and, if so, the frequency of this activity;

Q. State whether YOU did any cutting of ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment and, if so, the frequency of this activity;

R. State whether YOU did any drilling of ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment and, if so, the frequency of this activity at each place of employment;

S. State whether YOU removed any ASBESTOS-CONTAINING FRICTION PRODUCTS from MOTOR VEHICLES at each place of employment;

T. IDENTIFY by manufacturer and type each ASBESTOS-CONTAINING FRICTION PRODUCT by YOU removed by manufacturer and type (e.g., brake linings by ABC Corp. and XYZ Corp.);

U. Describe any WRITTEN INFORMATION which indicated the identity of the manufacturer of any ASBESTOS-CONTAINING FRICTION PRODUCTS YOU removed at each place of employment;

V. Describe the type of each MOTOR VEHICLE on which YOU performed work with ASBESTOS-CONTAINING FRICTION PRODUCTS (e.g., car, light truck, heavy truck, tractor, bus, etc.);

W. IDENTIFY the manufacturer of each MOTOR VEHICLE on which YOU performed work with ASBESTOS-CONTAINING FRICTION PRODUCTS;

X. Completely describe any work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by others which YOU contend caused an asbestos exposure to YOU;

Y. For each occasion on which YOU contend work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by others caused an asbestos exposure to YOU, state YOUR proximity to the work performed;

Z. IDENTIFY every supplier from whom YOU obtained ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment;

AA. For each supplier IDENTIFIED above, state the years in which you obtained ASBESTOS-CONTAINING FRICTION PRODUCTS from that supplier;

BB. Describe any safety equipment or protective devices for use with ASBESTOS-CONTAINING FRICTION PRODUCTS provided to YOU or YOUR coworkers at each place of employment;

CC. Describe any safety equipment or protective devices YOU or YOUR coworkers were required to use with ASBESTOS-CONTAINING FRICTION PRODUCTS at each place of employment;

DD. Describe any safety equipment or protective devices for use with ASBESTOS-CONTAINING FRICTION PRODUCTS used by YOU or YOUR coworkers at each place of employment;

EE. IDENTIFY all documents which support YOUR contention that YOU were exposed to asbestos from any ASBESTOS-CONTAINING FRICTION PRODUCT (not including documents obtained from other defendants through discovery);

3. Do YOU contend that YOU were exposed to asbestos from any ASBESTOS-CONTAINING FRICTION PRODUCTS anywhere other than a place of employment (i.e., during home auto repair)? If so, please state for each such exposure:

   A. The location where YOU contend each such exposure took place;

   B. The dates of each exposure;

   C. For each such exposure, IDENTIFY the owner of the MOTOR VEHICLE on which YOU performed work with ASBESTOS-CONTAINING FRICTION PRODUCTS;

   D. For each such exposure, IDENTIFY any person who observed YOU working with ASBESTOS-CONTAINING FRICTION PRODUCTS;

   E. For each such exposure, IDENTIFY any other person with knowledge of YOUR alleged exposure to ASBESTOS-CONTAINING FRICTION PRODUCTS;

   F. For each such exposure, provide a complete description of any work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by YOU which YOU contend caused an asbestos exposure to YOU;

G. For each such exposure, describe the specific parts or components YOU worked with which YOU contend were ASBESTOS-CONTAINING FRICTION PRODUCTS;

H. For each brake replacement, describe the method used to clean the brake assembly, including the tools and equipment used;

I. For each clutch replacement, describe the method used to clean the clutch assembly, including the tools and equipment used;

J. For each such exposure, IDENTIFY by manufacturer and type the replacement ASBESTOS-CONTAINING FRICTION PRODUCT installed by YOU (e.g., brake linings by ABC Corp. and XYZ Corp.);

K. For each such exposure, whether YOU did any arcing of ASBESTOS-CONTAINING FRICTION PRODUCTS;

L. For each such exposure, whether YOU did any grinding of ASBESTOS-CONTAINING FRICTION PRODUCTS;

M. For each such exposure, whether YOU did any sanding of ASBESTOS-CONTAINING FRICTION PRODUCTS;

N. For each such exposure, whether YOU did any cutting of ASBESTOS-CONTAINING FRICTION PRODUCTS;

O. For each such exposure, whether YOU did any drilling of ASBESTOS-CONTAINING FRICTION PRODUCTS;

P. For each such exposure, whether YOU removed any ASBESTOS-CONTAINING FRICTION PRODUCTS from a MOTOR VEHICLE;

Q. For each such exposure, IDENTIFY by manufacturer and type each ASBESTOS-CONTAINING FRICTION PRODUCT removed by YOU removed (e.g., brake linings by ABC Corp. and XYZ Corp.);

R. For each such exposure, describe any WRITTEN INFORMATION which indicated the identity of the manufacturer of any ASBESTOS-CONTAINING FRICTION PRODUCTS YOU removed;

S. For each such exposure, describe the type of MOTOR VEHICLE on which YOU performed work with ASBESTOS-CONTAINING FRICTION PRODUCTS (e.g., car, light truck, heavy truck, tractor, bus, etc.);

T. For each such exposure, IDENTIFY the manufacturer and model year of MOTOR VEHICLE on which YOU performed work with ASBESTOS-CONTAINING FRICTION PRODUCTS;

U. For each such exposure, provide a complete description of any work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by others which YOU contend caused an asbestos exposure to YOU;

V. For each occasion on which YOU contend work performed with ASBESTOS-CONTAINING FRICTION PRODUCTS by others caused an asbestos exposure to YOU, state YOUR proximity to the work performed;

W. Please IDENTIFY every supplier from whom YOU obtained ASBESTOS-CONTAINING FRICTION PRODUCTS;

X. For each supplier IDENTIFIED above, state the years in which YOU obtained ASBESTOS-CONTAINING FRICTION PRODUCTS from that supplier;

Y. For each such exposure, describe any safety equipment or protective devices for use with ASBESTOS-CONTAINING FRICTION PRODUCTS used by YOU;

Z. IDENTIFY all documents which support YOUR contention that YOU were exposed to asbestos from any ASBESTOS-CONTAINING FRICTION PRODUCT (not including documents obtained from other defendants through discovery).

4. Have YOU ever received any formal instruction or training in MOTOR VEHICLE inspection, repair, maintenance or mechanics? If so, please state:

   A. Where YOU received such training;

   B. When YOU received such training;

C. By whom the training was given, noting corporate identity as well as name and address of individual(s);

D. The subject or topics involved;

E. The systems or parts of the MOTOR VEHICLE involved;

F. Whether any safety equipment or protective devices with respect to asbestos were discussed and/or advised and, if so, describe the equipment/devices; and

G. Whether the subject of asbestos (asbestos parts, asbestos health hazards, etc.) was discussed and, if so, what was said;

5. Were technical or ship manuals ever made available to YOU at any place of employment where YOU performed MOTOR VEHICLE repairs? If so, please state:

   A. At which place of employment or training or in what other circumstances the manuals were made available;

   B. The time periods during which the manuals were made available;

   C. The identity of the manual (i.e., Chilton's, etc.);

   D. What systems or components were covered in the manuals; and

   E. YOUR use of the manual (including the frequency of use, reasons for use, etc.).

6. Are YOU contending that any defect or defective condition exists with respect to ASBESTOS-CONTAINING FRICTION PRODUCTS other than a failure to warn? If so:

   A. Set forth YOUR contention with respect to the alleged defect or defective condition;

   B. State all facts upon which YOU base YOUR contention that a defect or defective condition (other than a failure to warn) exists with respect to ASBESTOS-CONTAINING FRICTION PRODUCTS;

   C. IDENTIFY all documents and/or writings upon which YOU rely in so contending; and

D. IDENTIFY all witnesses who have knowledge of the facts upon which YOU rely in so contending.

7. Are YOU contending that any warnings regarding ASBESTOS-CONTAINING FRICTION PRODUCTS given were inadequate or insufficient? If so, please state:
   A. State YOUR contention as to each manufacturer or supplier of ASBESTOS-CONTAINING FRICTION PRODUCTS to which YOU contend YOU were exposed;
   B. State YOUR contention as to how each warning was insufficient;
   C. State YOUR contention as to what a proper warning should have been;
   D. IDENTIFY the witnesses who have personal knowledge of the facts which support any of the contentions set forth above.
8. Do YOU contend that any misrepresentations were made to YOU by any manufacturer or supplier of ASBESTOS-CONTAINING FRICTION PRODUCTS? If so, please state:
   A. The nature or substance of the misrepresentation;
   B. By whom it was made;
   C. To whom it was made; and
   D. When it was made.
9. Do YOU contend that there was a violation of any state or federal law or regulation by any manufacturer or supplier of the ASBESTOS-CONTAINING FRICTION PRODUCTS to which YOU contend YOU were exposed? If so, state specifically and in detail and by citation each and every state or federal law or regulation YOU contend was violated and state the name of each manufacturer and/or supplier YOU contend committed the violations.
10. Were YOU/are YOU licensed or certified by any local, state or federal authority to perform work upon MOTOR VEHICLES? If so, please state:
   A. By whom YOU were or are licensed or certified;

B. When YOU were licensed or certified;

C. What the requirements were/are to become licensed or certified;

D. Whether YOU had to pass any written examinations to become licensed or certified;

E. Whether YOU had to pass any proficiency examinations to become licensed or certified;

F. Whether YOU were ever retested or recertified and, if so, the dates of the retesting or recertification; and

G. Whether YOUR license or certificate was revoked or suspended and, if so, when and why.

11. Did YOU ever complain about working conditions, specifically any potential hazards of working with ASBESTOS-CONTAINING FRICTION PRODUCTS? If so:

A. To whom did YOU complain;

B. When did YOU complain;

C. Describe the specific nature of YOUR complaint;

D. What action, if any, was taken to rectify the situation;

E. State when such action was taken;

F. State whether YOU repeated the complaints if no action was taken;

G. State whether YOUR coworkers joined in YOUR complaints;

H. IDENTIFY anyone who may have heard YOU make YOUR complaints; and

I. State whether YOUR complaints were made orally or in writing.

12. To YOUR knowledge, were any air samplings for asbestos levels taken at any of the locations at which YOU worked? If so, please state:

A. The work location or place of employment where this occurred;

B. When the sampling(s) took place;

C. By whom the sampling was performed;

D. By what method the sampling was performed; and

E. The results of the sampling.

13. To YOUR knowledge, did any governmental agency, federal, state or local, conduct any inspection of any of YOUR work locations/places of employment? If so, please state:

A. Name and address of each work place;

B. Date(s) of inspection;

C. Purpose of inspection;

D. Findings of the inspection; and

E. Whether any changes (of the facilities, equipment or in procedures) were instituted in the work environment within three months of the inspection.

14. At any time, were YOU aware of or did YOU read any bulletins, newsletters or similar publications regarding ASBESTOS-CONTAINING FRICTION PRODUCTS or asbestos-related health hazards issued by any manufacturer, distributor or seller of ASBESTOS-CONTAINING FRICTION PRODUCTS, governmental agency, dealership association, union, organization of MOTOR VEHICLE mechanics or any other group, association or organization? If so, please state:

A. The title of the publication;

B. The date of the publication;

C. The identity of the group publishing the document;

D. Where YOU saw the document (at the place of employment or mailed to YOUR home);

E. When YOU saw the document (received regularly or on an intermittent basis and the time frame of receipt);

F. The specifics or details of the information concerning asbestos health hazards allegedly arising from ASBESTOS-CONTAINING FRICTION PRODUCTS; and

G. What, if anything, YOU did in response to the information contained in this publication (including complaints to employers).

15. Are YOU Medicare-eligible? If so, please state:

A. Whether you are currently enrolled in Medicare;

B. If you are not currently enrolled in Medicare, whether you have previously been enrolled;

C. The dates on which you are or were enrolled in Medicare;

D. YOUR Medicare number.

16. Has any person other than YOU received or sought treatment from Medicare for any reason related to your claims in this case? If so, please state, for each such person:

A. The name, address, and telephone number;

B. The person's relation to you (e.g. spouse, natural child);

C. The person's Medicare number;

D. The inclusive dates of such treatment.

17. Have YOU filed a claim against a bankruptcy trust? If "yes," state for each claim:

A. The name and address of that trust;

B. The date YOUR claim was filed;

C. Either (1) attach all DOCUMENTS evidencing the information sought in this interrogatory to your answers to interrogatories, or (2) attach disks containing such data, or (3) describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

Exhibit F

DEFENDANTS' STANDARD REQUESTS FOR PRODUCTION AND IDENTIFICATION OF DOCUMENTS AND THINGS TO PLAINTIFFS

Plaintiff(s) above named is/are hereby requested, within 30 days, to identify and produce for inspection and copying the records and things described hereinbelow.

The below described documents are currently in your possession, custody or control, are not privileged, and are relevant to the subject matter of this action or reasonably calculated to lead to the discovery of admissible evidence in this action.

INSTRUCTIONS

1. You are requested to produce not only those writings and any indices thereto in your possession, custody or control, but also those writings reasonably available to you, including those in the possession, custody or control of your attorneys, agents, or any other person acting on your behalf.

2. You are requested to produce all writings in the same form and order as they were kept prior to this notice to produce.

3. In the event you are able to produce only some of the writings called for in a particular request, please produce all writings you are able to produce.

4. Your responses must be verified under oath.

DEFINITIONS

1. "DOCUMENT" or "WRITING" are defined as in Evidence Code Section 250; and these words refer to all such materials, however produced or reproduced, in your actual or constructive possession, custody, care or control; and includes, but is not limited to, originals, copies, nonidentical copies, and preliminary, intermediate, and final drafts of all writings. Evidence Code Section 250 provides: "Writing means handwriting, typewriting, printing, photostating, photographing, and every other means of recording upon any tangible thing, any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof." A reference herein to any one or more of these types of writings shall be construed to include all other types of writings without limitation.

2. "YOU" and "YOUR" refers to plaintiff(s), the allegedly injured party, his/her agents, his/her attorneys, and anyone on his/her behalf.

3. "EXPOSED PERSON" means to state the complete name and address of each person whose claimed exposure to asbestos is the basis of this lawsuit.

4. As used herein, the term "MEDICAL TREATMENT FACILITY" means hospitals, dispensaries, laboratories, optometry clinics, psychological clinics, clinics of all other

kinds, mental institutions, radiology laboratories, pathology laboratories, rest homes, sanitariums, convalescent homes, and all other institutions, organizations, and facilities wherein are practiced the healing arts.

5. As used herein, the term "MEDICAL PRACTITIONER" refers to all physicians, osteopaths, dentists, chiropractors, nurses, psychiatrists, psychologists, optometrists, physical therapists, and all other persons practicing, or purporting to practice, the healing arts.

WRITINGS AND OTHER TANGIBLE ITEMS REQUESTED

1. All DOCUMENTS and WRITINGS (including photographs) concerning, illustrating, showing or describing any raw asbestos or materials or products containing asbestos that the plaintiff or exposed party allegedly used or to which the EXPOSED PERSON was allegedly exposed.

2. All DOCUMENTS in plaintiff's possession or under plaintiff's control that identify the retail and wholesale suppliers of the alleged asbestos-containing materials that caused the claimed injuries.

3. All DOCUMENTS and WRITINGS allegedly concerning, proving or indicating how the EXPOSED PERSON allegedly used the asbestos products and how the EXPOSED PERSON was allegedly exposed to the asbestos products.

4. All DOCUMENTS AND WRITINGS concerning or constituting communications (written or verbal) to or from any labor union concerning asbestos.

5. All DOCUMENTS and WRITINGS substantiating an income loss, loss of business, or damages due to the EXPOSED PERSON's physical condition, including W2 forms, wage statements, Social Security records, workers' compensation files, profit and loss statements, and documentation of retirement and/or pension plans.

6. All containers (e.g., boxes, cans, buckets, sacks, etc.) collected by, under the control or in the possession of the plaintiff evidencing or containing any raw asbestos or materials or products containing asbestos to which the EXPOSED PERSON claims to have been exposed.

7. Samples of all raw asbestos or materials or products containing asbestos to which the EXPOSED PERSON claims to have been exposed.

8. All DOCUMENTS and WRITINGS showing the names of employers, locations and jobs that the EXPOSED PERSON worked on, including any personal diaries, work diaries and photographs.

9. All DOCUMENTS and WRITINGS (e.g., articles, papers and/or notes) collected by, under the control or in the possession of plaintiff that concern health hazards associated with asbestos materials.

10. Copies of all medical bills incurred due to the EXPOSED PERSON's alleged medical condition(s) that are the subject of this lawsuit.

11. All DOCUMENTS and WRITINGS representing, recording or referring to any disability pension or disability insurance benefits received by the EXPOSED PERSON or claims/applications by the EXPOSED PERSON for such benefits.

12. All transcripts of testimony and statements under oath by plaintiff or the EXPOSED PERSON relating to the physical condition of plaintiff or the EXPOSED PERSON.

13. All DOCUMENTS and WRITINGS arising out of any employment of the EXPOSED PERSON at which the EXPOSED PERSON claims asbestos exposure including but not limited to personnel files, physical examinations, medical clearances and performance reviews.

14. (For the spouse of the EXPOSED PERSON only) marriage certificate(s) of the spouse of the EXPOSED PERSON in a loss of consortium action.

15. All DOCUMENTS and WRITINGS collected by, under the control or in the possession of plaintiff that identify the retail and wholesale suppliers of the alleged asbestos-containing materials that caused the claimed injuries.

16. If the EXPOSED PERSON is or was a proprietor of a business involving sale, use or distribution of asbestos-containing products, provide with respect to said business all purchase orders, purchase receipts, bills of lading, shipping and/or receiving documents, invoices or bills relating to the purchase, sale or use of any asbestos-containing products in the business, canceled checks, check registers, accounts payable ledgers, accounts receivable ledgers, general ledgers, accounting books and papers relating to the business, architectural specifications, books, product brochures or other literature, manuals, catalogs, price lists, reference guides, books or other papers received from suppliers or manufacturers relating to asbestos-containing products, packages or containers of asbestos-containing products

Exhibit G

NOTICE OF SERVICE OF PLAINTIFFS' CASE SPECIFIC STANDARD INTERROGATORIES TO DEFENDANTS

Plaintiff's case specific standard interrogatories are propounded to each of the following defendants:

The PREMISES, JOBSITES or WORKSITES including, if available, AREAS of IDENTIFIED WORK (collectively referred to as "DESCRIBED SITES") and the time periods for which said defendants are required to answer these interrogatories are:

Described Sites

Time Period

Plaintiff's counsel certifies that counsel has made a good faith effort to identify the "DESCRIBED SITES" and "TIME PERIOD" listed above by conferring to the extent reasonably possible with the plaintiff(s) and that to the best of counsel's knowledge the information sought has not been previously obtained from the defendant in answer to plaintiff's standard interrogatories to all defendants or the annual supplement thereto.

DATED: _____.

PLAINTIFFS' STANDARD CASE SPECIFIC INTERROGATORIES TO DEFENDANTS

PREFACE

Unless otherwise specifically set forth herein, the DESCRIBED SITE(S) for which you must respond are those listed in PLAINTIFF'S notice sent to you to initiate your responses to these Interrogatories and any other DESCRIBED SITE(S) known to you at which PLAINTIFF was exposed to asbestos.

Any information provided by any DEFENDANT in answer to General Order Interrogatories need not be repeated in answer to these followup interrogatories, except that a DEFENDANT must provide more specific information which is responsive to a specific designation of a DESCRIBED SITE if not included in previous answers. (Thus, for example, a DEFENDANT which has responded to the Standard Interrogatories regarding a particular facility in general must provide such information as it has regarding the particular unit in the facility identified as a PLAINTIFF'S DESCRIBED SITE.)

Hospitals and other health care entity defendants shall provide responses related only to that defendant's physical facilities and shall not be required to disclose any information related to the furnishing of services to patients.

DEFINITIONS

1. "AREA(S)" or "IDENTIFIED WORK" means the contract or subcontract, specific structure, building, building number, floor of the building, ship, process line, unit, piece of equipment or other specific place within each WORKSITE and PREMISES where PLAINTIFF worked and/or where the PLAINTIFF was exposed and/or the location that was the source of that exposure.
2. "ASBESTOSCONTAINING PRODUCT(S)" shall mean a product(s) which this defendant knows or believes to have contained any amount of the mineral asbestos at any time.
3. "COMPANY" means any private enterprise including corporations, partnerships, joint ventures, and sole proprietorships.
4. A "CONTRACT UNIT" shall mean a branch, division, subsidiary or other affiliated entity of a DEFENDANT which has been or is now engaged in installation, disturbing or handling and/or removal of RAW ASBESTOS and/or ASBESTOSCONTAINING PRODUCTS.

5. "DESCRIBED SITES" means the PREMISES, JOBSITES, or WORKSITES, including, if available, AREAS of IDENTIFIED WORK.
6. "DOCUMENT(S)" or "WRITING(S)" shall include all writings as defined by Section 250 of the California Evidence Code.
7. "GEOGRAPHIC AREA" means the 46 counties of Northern California (Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Kern, Kings, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba) and military facilities/installations in the State of California, or the following shipyards: Bethlehem Shipbuilding, San Pedro; California Shipbuilding, Terminal Island; Consolidated Steel Shipyard, Wilmington; Los Angeles Shipbuilding and Dry Dock aka L.A. Ship, San Pedro; National Steel and Shipbuilding Corporation, San Diego; Todd Shipyards Corporation, San Pedro; Triple "A" Machine, San Diego; Western Pipe and Steel Company, Los Angeles and San Pedro Divisions; Naval Air Station, North Island; Thirtysecond Street Naval Repair Facility, San Diego; Long Beach Naval Shipyard; and San Diego Destroyer Base.
8. Request to IDENTIFY a "WRITING" or "DOCUMENT" or study shall mean a request to either attach such an exhibit to your answers to these interrogatories, or to describe such with sufficient particularity that it may be made the subject of a request for production of documents. YOUR description should include an indication of: (a) the author; (b) addressee(s); (c) date of origin; (d) the nature of the writing or document (e.g., letter, telephone memorandum, audio tape recording, photograph, etc.); and (e) its present location, name and present address of custodian thereof.

9. A request to "IDENTIFY" an oral communication shall mean a request to describe the communication with particularity, and shall include the following information: (a) the identity of all parties to the communication; (b) the identity of the person whom you contend initiated the communication; (c) the identity of all persons present at the time of the communication; and (d) the time, date and place of the communication.

10. A request to "IDENTIFY" or to state the "IDENTITY" of a person or individual means to state his or her name, the place of employment, job title, present business or present or last known home address, years of employment and last known telephone number if not employed by DEFENDANT.

11. A request to "IDENTIFY" the product shall mean a request to describe the product, the material or compound by the following means: (1) by nickname or slang name used in your industry and/or occupation; (2) by the name under which it is sold in the marketplace (trade name); and (3) by its generic name.

12. "JOBSITE(S)" or "WORKSITE(S)" means any location other than a PREMISES at which PLAINTIFF claims exposure to asbestos.

13. "MARKET" (MARKETing, MARKETed) shall mean the mining, supply, sale, labeling, distribution, importing, processing or manufacture of RAW ASBESTOS and/or ASBESTOSCONTAINING PRODUCT(S).

14. A request to describe the "NATURE" of a product means to describe the: (a) color; (b) texture; (c) form (i.e., powder, liquid, paste, solid, board, cloth, blanket, wire insulation, etc.); (d) physical dimensions, if solid (length, width and height); (e) the type of shipping package and shipping package dimensions if not solid; (f) type of asbestos fiber used in the composition of the product (e.g., chrysotile, amosite, crocidolite); (g) the intended use or function of such product

as recommended by this DEFENDANT as the miner, producer, supplier, contractor, manufacturer, distributor, owner or seller; and (n) the type of worksite in which it was intended to be used (e.g., shipyard, refinery, commercial building construction, manufacturing plant, home, power generating plant, etc.).

15. "PREMISES" includes, but is not limited to, buildings, refinery facilities, boilers, generators, tract housing, commercial buildings and other such structures.

16. "RAW ASBESTOS" means asbestos fiber mined or milled, either packaged or in bulk, not compounded with other substances and essentially pure with the exception of naturally occurring trace amounts of other substances.

17. "THIS DEFENDANT" (or "DEFENDANT") shall mean the named defendant herein, all of its divisions, alternate entities, predecessors in interest, and successors in interest.

18. "YOU" and "YOUR" refer to the DEFENDANT who is named above as responding party.

INTERROGATORIES

INTERROGATORY NO.1 (For Contractor Defendants Only):

Did this DEFENDANT install, remove, disturb or handle or contract to have others do work which involved the installation, removal, disturbing or handling of RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS at any DESCRIBED SITE? If so,

A. IDENTIFY every contract to which YOU were a party or to which any of YOUR contractor(s) or subcontractor(s) were parties (regardless of the degree of removal) involving work at the DESCRIBED SITE at or before the time designated in the notice. For each such contract:

1. IDENTIFY the parties to the contract;
2. Provide a description of the work to be performed by each party to the contract and a description of the DESCRIBED SITE where work was to be performed under the contract;
3. IDENTIFY and describe the NATURE of the RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS

installed, removed, disturbed or handled in the performance of the contract;

4. IDENTIFY the person or entity from which the RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS were obtained;
5. State the dates of the contract and the dates of performance;
6. IDENTIFY all records which identify persons who worked at the DESCRIBED SITE.

B. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

C. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

INTERROGATORY NO.2 (To Manufacturer or Distributor Defendants only):

Were any of THIS DEFENDANT'S RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS sold, shipped, MARKETED, or otherwise distributed either to or for use at the DESCRIBED SITES at or before the time designated in the notice? If so:

A. IDENTIFY and state the NATURE and quantity of the RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS;

B. IDENTIFY to whom said RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS were sold;

C. IDENTIFY to whom said RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS were shipped;

D. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

E. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

INTERROGATORY NO.3 (for Premises Defendants only):

Did YOU install, remove, handle or disturb RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS at any DESCRIBED SITE at or before the time designated in the notice? If so:

A. IDENTIFY the PREMISES.

B. For each of the PREMISES:

1. State the nature of your ownership or possessory interest;
2. State the inclusive date of that interest;
3. IDENTIFY the party from whom that interest was acquired;
4. IDENTIFY the party, if any, to whom that interest was transferred.

C. IDENTIFY every contract to which YOU were a party or of which YOU have knowledge wherein the performance of such contract involved the installation, removal, disturbing or handling of any RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS at YOUR PREMISES. For each such contract:

1. IDENTIFY the parties to the contract;
2. Provide a general description of the work to be performed by each party to the contract;
3. IDENTIFY and describe the NATURE of the RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS installed, removed, disturbed or handled in the performance of the contract;
4. State the dates of the contract and the dates of performance;

D. Except as provided in response to subpart (C), has any work other than routine maintenance been done on or to the PREMISES that involved the installation, removal, disturbing or handling of RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS? If so, for each such instance:

1. State the inclusive dates of the work;
2. State the specific location of the work;
3. Provide a general description of the work;
4. State whether the work was done by YOU or YOUR employees;
5. IDENTIFY and describe the NATURE of the RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS installed, removed, handled or disturbed;
6. IDENTIFY from whom the RAW ASBESTOS OR ASBESTOSCONTAINING PRODUCTS were acquired.

E. Has any asbestos abatement effort been made at the DESCRIBED SITES? If so, for each such effort:

1. IDENTIFY who did the work;
2. State the inclusive dates thereof;
3. State whether samples were taken, and, if the samples still exist, IDENTIFY the custodian of the samples;
4. State whether any material was tested, and, if so, what were the results of each test;
5. IDENTIFY each test result with sufficient particularity for purposes of a request for production of documents, or, in the alternative, attach a copy to YOUR answers to these interrogatories.

F. Except for insurance coverage litigation, have you filed suit against, or otherwise sought to recover from, any person or entity for some or all of the cost of asbestos abatement or for the property damage allegedly caused by the presence of RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS on the PREMISES? If so:

1. IDENTIFY the person or entity against whom YOU have filed suit or otherwise sought to recover;
2. If YOU have filed suit, state the court in which the action was filed, the date on which it was filed, IDENTIFY all Plaintiffs and Defendants and their counsel of record;

3. State whether or not the case has been resolved, and, if so, what was the status or disposition.

G. Either attach all DOCUMENTS, or disks containing such data, evidencing the information sought in this Interrogatory and its subparts to your answers to these Interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

H. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

INTERROGATORY NO.4 (Premises and Contractor Defendants Only):

At or before the time designated in the notice, did YOU require PLAINTIFF to wear a respirator or face mask? If so:

A. IDENTIFY the individual(s) who communicated this requirement to the PLAINTIFF;

B. State the date(s) this requirement was first communicated to the PLAINTIFF;

C. State the means by which this requirement was communicated;

D. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

E. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

INTERROGATORY NO.5 (Premises Defendants Only):

Did YOU supply contractor or subcontractors with any tools or equipment to be used by contractors or subcontractors (or their employees) working in the AREA where the PLAINTIFF worked at the DESCRIBED SITES during the installation, removal, handling or disturbing of RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS? If so, for each occasion:

A. Describe the tools or equipment supplied;

B. IDENTIFY to whom the tools or equipment were supplied;

C. State the inclusive dates;

D. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

E. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

INTERROGATORY NO.6

Was air sampling ever conducted at any of the DESCRIBED SITES in which YOU had an ownership or possessory interest or where YOU performed services or where YOUR products were installed? If so, for each occasion:

A. Describe why the sampling was conducted;

B. Describe the results thereof;

C. Set forth the dates on which said samplings were performed;

D. Describe the location or locations within the DESCRIBE SITE where the samplings were obtained;

E. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

F. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

INTERROGATORY NO.7:

At any time during or after the time designated in the notice, was bulk sampling conducted at any of the DESCRIBED SITES in which you had an ownership or possessor interest? If so:

A. Describe why the sampling was conducted;

B. Describe the results thereof;

C. Set forth the dates on which such samplings were performed;

D. Describe the location or locations within the DESCRIBED SITE where the samplings were obtained;

E. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

F. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

INTERROGATORY NO.8 (Premises and Contractor Defendants Only):

For each instance that work was performed by contractors or subcontractors at any of the DESCRIBED SITES involving the installation, the disturbing, handling or removal of RAW ASBESTOS or ASBESTOSCONTAINING PRODUCTS, state what measures, if any, were taken by YOU or YOUR employees to provide a safe working environment as regards asbestos exposure in the AREAS where the PLAINTIFF worked at the designated times.

A. IDENTIFY the person(s) presently most knowledgeable about the information sought in this interrogatory or its subparts.

B. Either attach all DOCUMENTS, or discs containing such data, evidencing the information sought in this interrogatory and its subparts to your answer to these interrogatories, or describe such DOCUMENTS with sufficient particularity that they may be made the subject of a request for production of documents.

INTERROGATORY NO.9:

IDENTIFY each person who prepared or assisted in the preparation of the responses to these interrogatories. (Do not identify anyone who simply typed or reproduced the responses.)

INTERROGATORY NO.10:

If any person YOU have identified in YOUR answers to these interrogatories has had his or her deposition taken, IDENTIFY the deposition by the name of the deponent, the date the deposition was taken, the caption and number of the action in which it was taken, the court which had jurisdiction over the action in which it was taken (including state and county), and either the name and address of the court reporting agency which took the deposition or the name and address of deponent's counsel of record.

Exhibit H-1 – H-13

Exhibit H-1

Authorization for Medical Records

HIPAA COMPLIANT AUTHORIZATION FOR MEDICAL RECORDS PURSUANT TO 45 CFR 164.508

TO: _____
_____
_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, any and all medical information including but not limited to charts, records, reports, histories, laboratory studies, notes, x-rays and/or outpatient records, all chest x-rays, CT scans, cytology, pathology (including all slides and paraffin blocks) and PFT data and printouts pertaining to:

Patient Name: _____;
Date of Birth _____;
Social Security Number: _____

for purposes of review, evaluation and evidence in connection with a lawsuit filed on _____.

I acknowledge the right to revoke this authorization by writing to the ROA Agent at RecordTrak at 130 Webster Street, Suite # 100, Oakland, CA 94607. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization is given in compliance with the Federal Confidentiality Law (21 U.S.C. Section 1175, 42 CFR Subsection 2.1-2.67.1 and Health & Safety Code Section 199.21(g) and California Civil Code Section 56, et seq.) and specifically allows you to release alcohol, drug, psychiatric, sickle cell anemia information and/or HIV test results which are not unequivocally negative.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year. I understand that I have a right to receive a copy of this authorization upon request.

Copy requested and received: [ ] Yes [ ] No Initials: _____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

Is this case subject to trial preference? [ ] Yes [ ] No

Dated: _____ _____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-2

Authorization for Medical Bills

HIPAA COMPLIANT AUTHORIZATION FOR BILLING RECORDS PURSUANT TO 45 CFR 164.508

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607, or their representatives, in connection with a legal claim, the following information for any time whatsoever pertaining to the following patient for purposes of review, evaluation and evidence in connection with a lawsuit filed on _____.

Patient Name: _____;
Date of Birth _____; Social Security Number: _____

As used in this Authorization, "DOCUMENTS" means a writing, as defined in evidence Code Section 250, and includes the original or a copy without limitation of every kind of written, printed, typed, recorded, or graphic matter, however produced or reproduced, including but not limited to notes, forms, claims, memoranda, briefs, summaries, charts, medical records, transcripts and correspondence concerning or relating to the individual referenced above.

- Any and all billing records and statements which relate or pertain to any treatment, service, payment, credit, adjustment, or transaction of any type.
- Any and all documents reflecting payments made by Medicare, MediCal, Medicaid and/or any other medical insurance.
- Any and all documents reflecting any payments made by the patient on his/her own behalf.
- Any and all documents reflecting the medical charges to date and the current balance of the account.
- Any and all documents reflecting the total cost of each of the patient's medical treatments at the said facility, and the breakdown of the amount actually paid by and/or due from each payee, including but not limited to the patient, Medicare, MediCal, Medicaid and/or any other medical insurance.
- Any and all documents showing the amount discounted/reduced by your facility or its contracting agency from the total medical charges.
- Any and all contracts between Medicare, MediCal, Medicaid and your facility or contracting agency, physicians, employees and/or any other agents or representatives of your facility.
- Any and all documents contained in completed UB-92 or HFCA 1500 forms, such as ICD-9 diagnosis and procedure codes, including any E-codes, CPT codes, and DRG codes. Payment documentation should include explanations of reviews and/or explanations of benefit forms detailing the payments accepted for services provided to the patient.
- Any and all documents entitled CMS or Medicare Summary Notice.

This authorization is given in compliance with the Federal Confidentiality Law (21 U.S.C. Section 1175, 42 CFR Subsection2.1-2.67.1 and Health and Safety Code Section 199.21(g) and California Civil Code Section 56 et seq.) and specifically allows you to release alcohol, drug, psychiatric, sickle cell anemia information and/or HIV test results which are not unequivocally negative.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. (552 a(b)) and the California Confidentiality of Medical Information Act (C.C. Subsection 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived.

This authorization is effective immediately and shall remain in effect for one year. I understand that I have a right to receive a copy of this authorization upon request. Copy requested and received: ☐Yes ☐No Initials:_____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

I acknowledge the right to revoke this authorization by notifying the record custodian in writing at the facility identified above of my desire to revoke it. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508. I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

Signature: _____ Date: _____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-3

Authorization for Employment Records

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, **130 WEBSTER STREET, Suite 100, Oakland, CA 94607**, or their representatives, any and all employment records including but not limited to employment applications, personnel files, job descriptions and assignments, performance evaluations, attendance records, correspondence, wage and salary information, medical records and medical bills, accident reports, compensation and disability claims, insurance coverage information, pension records, and any and all employee benefits pertaining to _____; Date of Birth _____; Social Security Number: _____, for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year.
I understand that I have a right to receive a copy of this authorization upon request.

Copy requested and received: ☐Yes ☐No Initials:_____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

Date: X_____ X_____

_____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-4

Authorization for Union/Health & Welfare Records

AUTHORIZATION FOR RELEASE OF UNION/HEALTH & WELFARE RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, **130 WEBSTER STREET, Suite 100, Oakland, CA 94607**, or their representatives, any and all union records including but not limited to union dues statements, membership records, dispatch slips, employers and employment sites, beneficiary records, health and welfare trust records, pension records, accident reports, compensation and disability claims, medical records and medical bills, union literature regarding health and safety procedures and writings reflecting meetings on health and safety issues pertaining to _____; Date of Birth _____; Social Security Number: _____, for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year.
I understand that I have a right to receive a copy of this authorization upon request.
Copy requested and received: ☐Yes ☐No Initials:_____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

Date: X_____ X_____

_____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-5

Authorization for Death Certificate

AUTHORIZATION FOR RELEASE OF RECORDS – DEATH CERTIFICATE

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, **130 WEBSTER STREET, Suite 100, Oakland, CA 94607**, or their representatives, the **Death Certificate** pertaining to _____; Date of Birth _____; Social Security Number: _____, for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.

Copy requested and received: ☐Yes ☐No Initials:_____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

Is this case subject to trial preference? ☐Yes ☐No

Date: X_____ X_____

_____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-6

Authorization for Funeral Records

AUTHORIZATION FOR RELEASE OF FUNERAL RECORDS

TO: _____

_____

_____

I, _____, hereby authorize you to release to and/or permit inspection and copying by RECORDTRAK, **130 WEBSTER STREET, Suite 100, Oakland, CA 94607**, or their representatives, any and all **Funeral records** pertaining to _____; Date of Birth _____; Social Security Number: _____, for purposes of review, evaluation and evidence in connection with a lawsuit filed _____.

This authorization is given in compliance with the Federal Privacy Act (5 U.S.C. Section 552a(b)) and to the extent applicable, the California Confidentiality of Medical Information Act (Civil Code Section 56.10, et seq.), the restrictions of which have been specifically considered and are hereby expressly waived. A photocopy of this authorization shall be valid as the original.

This authorization is effective immediately and shall remain in effect for one year.

I understand that I have a right to receive a copy of this authorization upon request.

Copy requested and received: ☐Yes ☐No Initials:_____

It is also my understanding that RECORDTRAK is required by law to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact indicates plaintiff will seek trial preference, the first look is 7 days.

Is this case subject to trial preference? ☐Yes ☐No

Date: X_____ X_____

_____

The language of this Authorization has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff' attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-7

Authorization for Social Security Earnings Records

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name | Social Security Number

Other Name(s) Used (Include Maiden Name) | Date of Birth (Mo/Day/Yr)

2. What kind of information do you need?

☒ Detailed Earnings Information (If you check this block, tell us below why you need this information.) For the period(s)/year(s):

Civil Litigation

☐ Certified Total Earnings For Each Year. (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s):

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $

Do you want us to certify this information? ☒ Yes ☐ No

If yes, enter $16.00 . . . . . B. $

ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

SIGN your name here (Do not print) > Date

Daytime Phone Number (With Area Code) Telephone Number

5. Tell us where you want the information sent. (Please print)

Name RecordTrak Services Address 130 Webster Street Suite #100

City, State & Zip Code Oakland, California 94607

6. Mail Completed Form(s) To: Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33008
Baltimore Maryland 21290-3008

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

*RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Exhibit H-8

Authorization for Social Security Disability Records

Social Security Administration
Consent for Release of Information

Form Approved
OMB No. 0960-0566

*SSA will not honor this form unless all required fields have been completed (*signifies required field).*

TO: Social Security Administration

*Name | *Date of Birth | *Social Security Number

I authorize the Social Security Administration to release information or records about me to:

*NAME	*ADDRESS
RECORDTRAK	130 Webster Street, Suite 100
*See below	Oakland, CA 94607

*I want this information released because:
There may be a charge for releasing information.

*Please release the following information selected from the list below:
You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.

- [ ] Social Security Number
- [x] Current monthly Social Security benefit amount
- [x] Current monthly Supplemental Security Income payment amount
- [ ] My benefit/payment amounts from _____ to _____
- [x] My Medicare entitlement from _____ XX FOR ALL TIME
- [ ] Medical records from my claims folder(s) from _____ to _____
  If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.
- [x] Complete medical records from my claims folder(s)
- [x] Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.)

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 U.S.C. § 1746(1)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that any applicable fees must be paid by me.

*Signature: _____ *Date: _____

Relationship *(if not the individual)*: _____ *Daytime Phone: _____

Form SSA-3288 (07-2010) EF (07-2010)

*RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Exhibit H-9

Stipulation for Military Records

Evanthia M. Spanos, Esq. (CSB #111178)
BERRY & BERRY
A Professional Corporation
2930 Lakeshore Avenue
Oakland, CA 94610-3614
Telephone: (510) 835-8330
Facsimile: (510) 835-5117

Designated Defense Counsel

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SOLANO

_____, et al. Plaintiff(s), vs. _____, et al. Defendants	No. _____ STIPULATION RE: RELEASE OF RECORDS AND ORDER

Plaintiff above named and all defendants do hereby stipulate and agree to entry of an order of this Court compelling release of all records in the possession, custody and/ or control of the Custodian of Records, National Personnel Records Center, St. Louis, Missouri, including but not limited to, medical, employment, workers' compensation and military records pertaining to: _____; Place of Birth: _____; Employed at: _____; from: _____; Government Serial No.: _____; Branch of Military Service: _____; from: _____; Military Serial Number: _____.

The Federal Privacy Act has been specifically considered in entering this stipulation.

It is further stipulated that all records be released directly to RECORDTRAK, 130 WEBSTER STREET, Suite 100, Oakland, CA 94607 for copying, without the necessity of a formal motion and that **RECORDTRAK** is required by law to send any records they obtain to plaintiff's counsel for a 21 day first look before sending them to any defendant. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Dated:_____

By_____
Attorney for Plaintiff

Dated:_____

BERRY & BERRY
A Professional Corporation

By_____
Evanthia M. Spanos, Esq.
Designated Defense Counsel

ORDER

IT IS HEREBY ORDERED that the custodian of Records, National Personnel Records Center, St. Louis, Missouri, produce all records in his possession, custody and/or control pertaining to, _____, including but not limited to, medical, employment, and Workers' Compensation records, all pursuant to 5 U.S.C. Section 522a(b)11. The Federal Privacy Act has been specifically considered in ordering the release of these records and this order is made pursuant to that Act. IT IS FURTHER ORDERED that the records be released directly to **RECORDTRAK**, and that the copies of any records received will be provided to plaintiff's counsel for a 21 day first look before sending them to any defendant. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Dated:_____

_____
Judge of the Superior Court

The language of this Stipulation has been authorized by the Solano County Superior Court. No alteration of or deletion to this form may be made by plaintiff or plaintiff's attorney without Order of the Solano County Superior Court on noticed Motion.

Exhibit H-10

Authorization for Medical Records from Military Facilities

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use of an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one)
	[ ] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ (Name of Facility/TRICARE Health Plan) TO RELEASE MY PATIENT INFORMATION TO:

a. NAME	b. ADDRESS (Street, City, State and ZIP Code)
RECORDTRAK *	130 Webster Street, Suite 100 Oakland, CA 94607
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)

[ ] PERSONAL USE	[ ] CONTINUED MEDICAL CARE	[ ] SCHOOL	[X] OTHER (Specify) Asbestos Litigation
[ ] INSURANCE	[ ] RETIREMENT/SEPARATION	[ ] LEGAL	

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION DATE (YYYYMMDD)	[ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I hereby name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)

SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: PMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

DD FORM 2870, DEC 2003

*RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Exhibit H-11

Authorization for Veteran's Records

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 3701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDTRAK, 130 Webster Street Suite #100 Oakland, CA 94607

Phone: (800) 220-3200 Fax: (510) 465-3200

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT HISTORY ☒ OTHER (Specify)

Any and all records including but not limited to disability claims, medical records and medical bills, pension records, veteran benefits, and Medicare and MediCal payments, reimbursements and inquiries from _____ to _____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Asbestos Litigation

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on [ ] (date supplied by patient); (3) under the following condition(s):

This authorization is effective immediately and shall remain in effect for one year.
RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM MAY 2005 10-5345

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

Exhibit H-12

Authorization for Military Records

Standard Form 180 (Rev. 10/10) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))

Authorized for local reproduction
Previous edition unusable

OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. Check the appropriate box below to specify a deleted or undeleted copy. When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☐ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission must be provided:

☐ **Other (Specify):**

2. PURPOSE: (An explanation of the purpose of the request is strictly voluntary; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal
☐ Other, explain:

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: *(Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above
☐ Next of kin of deceased veteran **(Must provide proof of death).**
Show relationship: _____
(See item 2a on accompanying instructions.)
☐ Legal guardian (Must submit copy of court appointment.)
☐ Other (specify) _____

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name _____

Street _____ Apt. _____

City _____ State _____ Zip Code _____

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

_____
Signature Required - Do not print

_____
Date of this request ( ) Daytime phone

_____
Email address

This authorization is effective immediately and shall remain in effect for one year.
RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

Exhibit H-13

Authorization for Veteran's Medical Records

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

RECORDTRAK, 130 Webster Street Suite #100 Oakland, CA 94607
Phone: (800) 220-3200 Fax: (510) 465-3200

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTES ☒ OTHER (Specify)

Include Films, Pathology and/or Cytology materials, Billing and payment information, Medicare & Medical payments for the period _____ to _____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Asbestos Litigation

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

This authorization is effective immediately and shall remain in effect for one year.
RECORDTRAK is required to provide my attorneys with copies of my records for a 21 day first look before sending them to any defendant involved in my asbestos case. If the preliminary fact sheet indicates plaintiff will seek trial preference, the first look is 7 days.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VA FORM MAY 2005 10-5345

USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004.

Exhibit H-14

Consents to Release Insurance Information

"Consent to Release"
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on:

- **When to use a "consent to release" document vs. a "proof of representation" document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a "Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:
MSPRC - NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____(print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:
(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier ( ) Other _____
(Explain)

Name of entity: _____

Contact for above entity: _____

Address: _____

_____

Telephone: _____

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.):

( ) One Year ( ) Two Years ( ) Other _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit www.mspre.info for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card.): _____

Date of Injury/Illness: _____

Exhibit H-15

Medicare Confidential Reporting Information

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev04-13)

Case Name:	Case Number:	17. State of Venue: (USPS Abbreviation)
Defendant Name:		

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare

Part A	Part B	Part C	Part D
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section A ALLEGED INJURED PARTY INFORMATION *(If living, provide address in Section G)*

4. Medicare Claim Number: (also known as HICN)			
5. Social Security Number:	6. Injured Party Last Name: (Please print name as it appears on Social Security card.)		
7. Injured Party First Name: (Please print name exactly as it appears on Social Security card.)	8. Injured Party Middle Name: (Please print name exactly as it appears on Social Security card.)		
9.Gender: ☐ Male ☐ Female	10. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):

Section B ALLEGED INCIDENT INFORMATION

12. CMS Date of Incident: Please state the date of the accident or date of first exposure, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

13. Industry Date of Incident: Please state the date of accident or date of last exposure, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

15. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes) optional field:

19. ICD-9 Diagnosis Code 1 (no decimal):

Provide valid ICD-9-CM Codes for any injury or illness you allege arose from the allegations made against settling defendant.

21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:

Description of Illness/Injury (Free Form Text Description):

Section C ALLEGED INJURED PARTY'S ATTORNEY or OTHER REPRESENTATIVE INFORMATION

84. Claimant Representative Type (please check one):

☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

85. Claimant Representative Last Name:	86. Claimant Representative First Name:	87. Claimant Representative Firm Name:
88. TIN/EIN, If Firm Entity; SSN. If Individual:	89-90. Representative Mailing Address:	

91. City:	92. State:	93-94. Zip Code +4:	95. Phone:	96. Ext. (If any):

OPTIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Section D If Section D Claimant has a representative other than Section C Representative, complete Section F

104. Claimant Relationship to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

105. TIN/EIN (Social Security, If Individuals):	*106. Claimant Last Name:*
107. Claimant First Name:	*108. Claimant Middle Initial:*
109. Claimant Entity/Organization Name:	
110. Mailing Address:	

112. City:	*113.State:*	*114. Zip Code+4:*	*116. Phone:*	*117. Ext. (If any):*

Section E SETTLEMENT INFORMATION

100. Date of Settlement:	101. Amount of Settlement:

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Section A-LOC	LOSS OF CONSORTIUM PLAINTIFF INFORMATION THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT PROVIDE ESTATE INFORMATION IN SECTION D

4-LOC. Medicare Claim Number: (also known as HICN)			
5-LOC. Social Security Number:	6-LOC. Last Name: (Please print name exactly as it appears on Social Security card.)		
7-LOC. First Name: (Please print name exactly as it appears on Social Security card.)	8-LOC. Middle Name: (Please print name/initial exactly as it appears on Social Security card.)		
9-LOC Gender: ☐ Male ☐ Female	10-LOC. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):
15-LOC. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes): (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 19-LOC)			
19-LOC. ICD-9 Diagnosis: (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)			

Signature of Attorney representing Plaintiff/Claimant(s) _____ Date _____ Printed Name

The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this form and that all information stated herein is well grounded in fact to the best of his/her knowledge, information and belief formed after reasonably inquiry.

*Numbers reflect claim input file field numbers, as set forth in Version 3.1 of the Official NGHP User Guide by CMS.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Case Name:	Case Number:
Defendant Name:	

Optional Section F — *CLAIMANT'S (found in Section D) ATTORNEY OR OTHER REPRESENTATIVE INFORMATION*

119. Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

120. Claimant Representative Last Name:	*121. Claimant Representative First Name:*	*122. Claimant Representative Firm Name:*
123. TIN/EIN, if Firm Entity; SSN, if Individual:	*124. Representative Mailing Address:*	

126. City:	*127. State:*	*128. Zip Code +4:*	*129. Phone:*	*130. Ext. (if any):*

Section G — **ALLEGED INJURED PARTY'S ADDRESS**

Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Optional Section D cont. — *ADDITIONAL CLAIMANT INFORMATION (Use only if Alleged Injured Party in Section A is deceased)*

Claimant Relation to Alleged Injured Party (please check one):
☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if Individuals):	*Claimant Last Name:*
Claimant First Name:	*Claimant Middle Initial:*
Claimant Entity/Organization Name:	
Mailing Address:	

City:	*State:*	*Zip Code +4:*	*Phone:*	*Ext. (if any):*

Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

Claimant Representative Last Name:	*Claimant Representative First Name:*	*Claimant Representative Firm Name:*
TIN/EIN, if Firm Entity; SSN, if Individual:	*Representative Mailing Address:*	

City:	*State:*	*Zip Code +4:*	*Phone:*	*Ext. (if any):*

Section B cont. — **Additional ICD-9 fields, if necessary**

31. ICD-9 Diagnosis Code 7:	33.ICD-9 Diagnosis Code 8:	35 ICD-9 Diagnosis Code 9:	37.ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43.ICD-9 Diagnosis Code13:	45.ICD-9 Diagnosis Code 14:	47.ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:

51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:

If additional Section D Claimants exist, use page 3 and duplicate page, if necessary.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

Field#	Field Name	Definition:
4	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Injured Party's Medicare Health Insurance Claim Number (if one has been issued).This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Injured Party's Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide last name of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
7	FIRST NAME	Provide first name of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
8	MIDDLE INITIAL	Provide middle initial of Alleged Injured Party EXACTLY AS IT APPEARS ON SOCIAL SECURITYCARD or Medicare Card if available.
9	GENDER	Indicate Alleged Injured Party's gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Injured Party's Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
12	CMS DATE OF INCIDENT	Provide Date of Incident (DOI), DOI as defined by CMS: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of FIRST exposure. For claims involving ingestion (for example, a recalled drug), it is the date of FIRST ingestion. For claims involving implants it is the date of the implant (or date of the first implant if there are multiple implants).
13	INDUSTRY DATE OF INCIDENT	Provide Industry Date of Incident (DOI) routinely used by the insurance/workers' compensation industry: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, or implantation, the date of incident is the date of LAST exposure, ingestion, or implantation.
15	OPTIONAL FIELD ALLEGED CUASE OF INJURY, ILLNESS OR INCIDENT	Claimant must provide either 1) both a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code (Field 19) OR 2) the Description of Illness/Injury(Field 67). Claims submitted on or after 1/1/11, Claimant must provide both a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code. (See notes above for Spouse Injury codes)
17	STATE OF VENUE	Provide the US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Use "US" where the claim is a Federal Tor Claims Act liability insurance matter or a Federal workers' compensation claim.
19-55	ICD-9 DIAGNOSIS CODE 1 - 19	(International Classification of Diseases, Ninth Revision, Clinical Modification) - Must be on the current list of valid codes accepted by CMS found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp At least one valid diagnostic code must NOT be on the list of insufficient codes (found in Appendix H to the NGHP User Guide, V. 2.0,and NOT an E or a V Code). (See notes above for Spouse injury codes)
57	RESERVED FOR FUTURE USE	Formerly used for the obsolete – Description of Illness / Injury
84	REPRESENTATIVE TYPE	Indicate the type of representative that the Alleged Injured Party has. Select from the options provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O= Other. If Alleged Injured Party has more than one representative, provide attorney information, if available.
85	REPRESENTATIVE LAST NAME	Provide Last Name of Representative.
86	REPRESENTATIVE FIRST NAME	Provide First Name of Representative.
87	REPRESETNATIVE FIRM NAME	Provide the Name of the Representative's Firm.
88	TIN/EIN, IF FIRM/ENTITY;SOCIAL SECURITY NUMBERIF INDIVIDUAL	Provide Alleged Injury Party's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
89	MAILING ADDRESS	Provide mailing address for the alleged injured party's representative named above.
91	CITY	Provide mailing address city for the alleged injured party's representative named above.
92	STATE	Provide mailing address state for the alleged injured party's representative named above
93	ZIP CODE +4	Provide mailing address zip code for the alleged injured party's representative named above. IncludeZip+4 code if known; if not known enter 0000.
95	PHONE	Provide telephone number of alleged injured party's representative.
96	PHONE EXTENSION, IF ANY	Provide telephone extension of alleged injured party's representative, if extension is available.
100	DATE OF SETTLEMENT	Date the Release is signed unless court approval is required - then it is the later of the date the Release is signed or thedate of court approval. If there is no written agreement, then it is the date of payment.
101	AMOUNT OF SETTLEMENT	Provide total amount of Settlement
104	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
105	TIN/EIN, IF ENTITY;SOCIAL SECURITY NUMBER,IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number(TIN)/Employer Identification Number (EIN) if claimant is an entity.
106	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
107	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
108	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
109	CLAIMANT	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 04-13)

	ENTITY/ORGANIZATION NAME	Estate of John Doe", "The Family of John Doe", "The Trust of John Doe" etc.
110	MAILING ADDRESS	Provide mailing address for claimant.
112	CITY	Provide mailing address city of the claimant.
113	STATE	Provide mailing address state of the claimant.
114	ZIP CODE+4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
116	PHONE	Provide telephone number of the claimant.
117	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
119	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of representative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored
120	CLAIMANT REPRESENTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
121	CLAIMANT REPRESENTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
122	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
123	TIN/EIN, IF FIRM/ENTITY; SOCIALSECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN); otherwise supply the representative's Social Security Number (SSN).
124	CLAIMANT REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
126	CLAIMANT REPRESENTATIVE CITY	Provide mailing address city for the claimant's representative.
127	CLAIMANT REPRESENTATIVE STATE	Provide mailing address state for the claimant's representative.
128	CLAIMANT REPRESENTATIVE ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
130	CLAIMANT REPRESENTATIVE PHONE	Provide telephone extension of claimant's representative, if extension is available.
131	CLAIMANT REPRESENTATIVE PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

Exhibit H-16

Affidavit of Medicare Non-Eligibility

[NAME(S)], et al.	*	IN THE
Plaintiff(s)	*	[COURT]
v.	*	FOR
[NAME(S)], et al.	*	[LOCATION]
Defendant(s)	*	CASE NO.

* * * * * * * * * * *

AFFIDAVIT OF MEDICARE NON-ELIGIBILITY

1. I, [PLAINTIFF], am over the age of eighteen (18) and am competent to be a witness in this matter. I have personal knowledge of the facts set forth herein.

2. I understand that in reaching a settlement, the parties have considered Medicare's interest in recovering conditional payments made for medical treatment rendered as a result of the claim that is the subject of my above- captioned lawsuit.

3. I have provided my Social Security Number and date of birth. I understand that if I am a Medicare beneficiary and I do not provide the requested information, including a Health Insurance Claim Number, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claim(s) correctly and promptly.

4. I hereby make the following representations and warranties in affirming that I am not eligible for Medicare:

   (a) I have not applied for Medicare benefits.

   (b) Medicare has made no conditional payments for any medical expense or prescription expense related to the claimed injury.

   (c) I am not, nor have I ever been a Medicare beneficiary.

   (d) I am not currently receiving Social Security Disability Benefits.

   (e) I have not applied for Social Security Disability Benefits.

   (f) I have not been denied Social Security Disability Benefits.

   (g) I have not appealed from a denial of Social Security Disability Benefits.

   (h) I am not in End Stage Renal Failure.

(i) I have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease.

(j) No liens, including but not limited to liens for medical treatment of the claimed injury, by hospitals, physicians, or medical providers of any kind, have been filed for the treatment of injuries sustained as related to the above-captioned lawsuit.

5. I assume all responsibility for all liens related to the treatment of the claimed injury, including those asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date of Birth Social Security Number

_____ _____

Date [PLAINTIFF]

Sworn and subscribed before me this _____ day of_____, 20___

_____

Notary Public

_____

My Commission Expires: