MALIGNANT CLAIM FORM & DECLARATION
Pittsburgh Metals Asbestos Settlement Trust

Submit claims to:

Website- mfrclaims.com

Or

Email- PMinquiries@mfrclaims.com

Or

Mail to-

Pittsburgh Metals Asbestos Settlement Trust
c/o MFR Claims Processing, Inc.
115 Pheasant Run Suite 112
Newtown, Pa 18940

For additional information, please refer to the **Instructions for Filing a Claim with the Pittsburgh Metals Asbestos Settlement Trust** and **the Pittsburgh Metals Asbestos Settlement Trust Distribution Procedures (the "TDP").**

Please review the instructions before completing this claim form.

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Please complete this claim form as thoroughly and accurately as possible. All applicable questions must be answered. Please type or print neatly. Should there be insufficient space to list relevant information, please attach additional sheets. In addition to filing this form, please ensure the following are enclosed

- Death Certificate (if applicable)
- Certificate of Official Capacity or other estate documentation (if personal representative is filing form) if applicable per state law
- Medical records as required by the Trust Distribution Procedures ("TDP") and as requested in the instructions
- Proof of PMP Exposure as set out in the instructions

Part 1: INJURED PARTY and CLAIM INFORMATION

1.1 Injured Party's Full Name: _____
[First Name] [Middle Name] [Last Name]

SSN: _____-_____-_____ Date of Birth: ____/____/_____
Month Day Year

Gender: ☐ M ☐ F

Injured Party's Contact Information (If Injured Party is living and not represented by Counsel)

Address: Street: _____ City:_____

State:_____ Zip Code:_____

Phone:_____

Email:_____

1.2 Is the Injured Party Living? ☐ Yes ☐ No

If No, provide the following:

Date of Death: _____/_____/_____
Month Day Year

Was the Death Asbestos related? ☐ Yes ☐ No

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Personal Representative's Full Name: _____
[First Name] [Middle Name] [Last Name]

Address: Street: _____ City: _____

State:_____ Zip Code:_____

Phone:_____

Email:_____

Relationship to Injured Party?:_____

Also provide Death Certificate and one of the Following (if required by state law) :

- Certificate of Official Capacity
- Other applicable document authorizing a person to act on behalf of the Injured Party

1.3 If represented by Counsel, Injured Party's Law Firm Contact Information

If claimant is not represented by counsel, please provide Claimant contact information above.

Firm Name: _____

Attorney Name: _____ Phone Number: _____

Email: _____

Para/ Admin Name: _____ Phone Number: _____

Email: _____

Address: _____

_____

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Part 2: DIAGNOSED DISEASES

DISEASE CLAIMED

Check the box indicating the highest disease level for which the Injured Party has been diagnosed. Attach medical evidence to support the claim. Provide the date of first diagnosis for the disease claimed.
See Instructions for Filing a Claim with the Pittsburgh Metals Asbestos Settlement Trust for the applicable medical evidence required for each disease.

Disease Level	**First Date of Diagnosis**
Disease Level II Other Cancer	
☐ Colorectal Cancer	_____/_____/_____
☐ Esophageal Cancer	_____/_____/_____
☐ Laryngeal Cancer	_____/_____/_____
☐ Pharyngeal Cancer	_____/_____/_____
☐ Stomach Cancer	_____/_____/_____
Disease Level III	
☐ Lung Cancer	_____/_____/_____
Disease Level IV	
☐ Mesothelioma	_____/_____/_____

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Part 3: LITIGATION

"PMP" means Pittsburgh Metals Purifying Company, Inc. and its predecessors, successors, and assigns.

1. Has an asbestos-related lawsuit ever been filed against PMP on behalf of the injured party?
Yes____ No____

a. State in which the suit was filed: _____

b. Name of court in which the suit was originally filed: _____

c. Case number: _____

d. Date the suit was originally filed: _____/_____/_____
(month) (day) (year)

e. If the suit resulted in any of the following, please check all that apply and provide the requested information.

- ☐ Settlement with PMP:
  Date_____ Amt _____ Amt received to date: _____
- ☐ Judgment against PMP:
  Date_____ Amt _____ Amt received to date: _____
- ☐ Jury verdict against PMP:
  Date_____ Amt _____ Status: _____
- ☐ Dismissal of PMP with prejudice:
  Date_____

2. If no suit was ever filed against PMP, please elect one of the following and identify the jurisdiction:

- ☐ State of exposure to PMP products: ____
- ☐ State of residence at time of filing (if Injured Party is living): ____
- ☐ State of residence at time of death (if Injured Party is deceased): _____
- ☐ State of residence at time of diagnosis: _____

3. Was a tolling agreement for the Injured Party ever in effect with respect to the claim(s) against PMP?
Yes____ No____ If "Yes", please submit copy of tolling agreement.

a. Date the tolling agreement began: _____/_____/_____
(month) (day) (year)

b. Date the tolling agreement ended: _____/_____/_____
(month) (day) (year)

4. Has a claim been filed with PMP pursuant to an administrative settlement agreement?
Yes____ No____ If "Yes", please provide a copy of the administrative settlement agreement.

a. Date the claim was originally filed: _____/_____/_____
(month) (day) (year)

b. Have you received money from PMP for this claim? Yes____ No___

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Part 4: OCCUPATIONAL EXPOSURE

See the TDP for exposure evidence necessary to meet the requirements for a valid and compensable claim.

Pursuant to TDP Section E.2, all claimants must demonstrate meaningful and credible exposure to a PMP asbestos product, which occurred prior to January 1, 1986 ("**PMP Exposure**"). Meaningful and credible exposure evidence may be established by an affidavit or sworn statement of the claimant, by an affidavit or sworn statement of a co-worker or the affidavit or sworn statement of a family member in the case of a deceased claimant (providing the Trust finds such evidence reasonably reliable), by invoices, construction or similar records, or by other credible evidence. Claimants alleging Disease Levels II (Other Cancer) and III (Lung Cancer) must demonstrate at least six (6) months of PMP exposure prior to January 1, 1986.

Please photocopy this section and list separately each employment site, industry, product and occupation combination upon which you rely to meet the exposure requirements of the TDP.

4.1 PMP Asbestos Exposure. Every claimant must submit evidence of exposure to PMP asbestos products or activities.

Employer: _____City: _____State: _____

Site/Location of Alleged Exposure: _____ City:_____State:_____

Date employment began: ____/___/_____Date employment ended: ____/___/_____

Date exposure began: _____/___/_____Date exposure ended: _____/___/_____

Profession/Job Description: _____

Describe exposure to PMP asbestos- containing product(s) including the identity of the product(s):_____

_____

_____

_____

_____

Attach all documents necessary to meet the meaningful and credible evidence of exposure requirements of the TDP.

4.2 Significant Occupational Exposure (SOE) for Claims other than Mesothelioma (Level IV) Claims. *[Please check all applicable statements.]*

Employment for a cumulative period of at least five (5) years prior to January 1, 1986 in an industry and an occupation in which the Injured Party:

☐ Handled raw asbestos fibers on a regular basis;

☐ Fabricated asbestos-containing products so that the Injured Party in the fabrication process was exposed on a regular basis to raw asbestos fibers;

☐ Altered, repaired or otherwise worked with an asbestos-containing product such that the Injured Party was exposed on a regular basis to asbestos fibers; or

☐ Was employed in an industry and occupation such that the Injured Party worked on a regular basis in close proximity to workers engaged in the activities described in the preceding categories.

If none of the above apply, provide a narrative description of how the claimant was occupationally exposed to asbestos at each site.

If exposure information provided in 4.1 above is not sufficient to meet the SOE requirements, please provide additional occupational exposure information below.

Employer: _____City: _____State: _____

Site/Location of Alleged Exposure: _____ City:_____State:_____

Date employment began: ____/___/_____Date employment ended: ____/___/_____

Date exposure began: _____/___/_____Date exposure ended: _____/___/_____

Profession/Job Description: _____

Describe exposure to asbestos- containing product(s) including the identity of the product(s):_____

_____

_____

_____

_____

_____

_____

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Part 5: MEDICARE REPORTING INFORMATION

If the Injured Party is under 65, please answer yes or no to each of the following questions:

- Has the Injured Party received Social Security or Railroad Retirement Board disability benefits for a period of at least 24 months? ☐ Yes ☐ No

- Does/did the Injured Party have ALS, more commonly known as Lou Gehrig's Disease?

  ☐ Yes ☐ No

- Does/did the Injured Party have End-Stage Renal Disease? ☐ Yes ☐ No

Provide the first and last date of exposure to PMP products:

First date of exposure: _____

Last date of exposure: _____

Provide the brand and generic name of the PMP products to which the Injury Party was exposed:

_____

If known, please provide the Injured Party's HICN number. _____

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Part 6: PROOF OF EXPOSURE

Proof of exposure may be demonstrated by one or more of the following:

The Injured Party, Attorney or Official Representative may demonstrate proof of exposure by completing **Part 7: CERTIFICATION** of this claim form, allowing the claim form to serve as the declaration.

OR

One or more of the following documents may be submitted to supplement credibility as to proof of exposure. The documents should be submitted as an attachment to the Claim Form and **Part 7: CERTIFICATION** section of this claim form must be signed.

- Affidavit or sworn statement of the claimant
- Affidavit or sworn statement of a co-worker or family member in the case of a deceased claimant (provided the Trust finds such evidence reasonably reliable)
- Invoices, employment, construction or similar records
- Other Evidence
    - Verified Listing of employer/jobsites
    - Verified Work History
    - Answers to Claimant Interrogatories with verification page.
    - Deposition Transcript with cover page(s)

Part 7: CERTIFICATION

Part 7: CERTIFICATION must be completed.

This claim is certified by (check one)

☐ Attorney

☐ Injured Party

☐ Personal Representative

I have reviewed the information submitted on this claim form and all documents submitted in support of this claim. Upon information and belief, under penalty of perjury, the information submitted is accurate and complete in all material respects.

_____

Signature of the Injured Party, Attorney or Personal Representative

_____

Printed name *Date*