

## GREEN FORM

### EXTRAORDINARY INJURY FUND (EIF) BENEFITS CLAIM FORM

#### AFFECTED PRODUCT RECIPIENT ONLY

This *Green Form* is to be used by any Class Member registering for settlement benefits from the Extraordinary Injury Fund (“EIF”). A timely *Blue* or *Orange Form* (whichever appropriate) must have been completed in addition to this EIF Benefits Form (*Green Form*). This completed form must be postmarked to the Claims Administrator (c/o Sulzer Settlement Trust, P.O. Box 94558, Cleveland, Ohio 44101-4558) on or before the date that is the later of:

- 545 days after the date of the applicable Covered Revision Surgery (“CRS”)<sup>1</sup>; or
- 180 days after a Non-Removal Surgery; or
- 180 days after the APR’s treating physician’s determination that an APRS would be indicated but for a medical condition(s); or
- 180 days after Trial Court Approval.

See the *Final Notice of Settlement of Nationwide Hip Prosthesis and Knee Prosthesis Product Liability Class Action Litigation (“Final Notice”)*, the *Class Member and Attorney Guide*, or the *Settlement Agreement* for further information. If there is any conflict between the provisions of this Claim Form and the terms of the Settlement Agreement, the terms of the Settlement Agreement control.

All responses must be **printed** or **typed**. By completing this *Green Form*, you<sup>2</sup> are registering for benefits under the Settlement Agreement. If you have retained an attorney regarding your claim, you should consult with your attorney about your options under the Settlement Agreement.

1. **Indicate by checking the appropriate box below whether the APR was implanted with a Sulzer Inter-Op™ Shell, a Reprocessed Inter-Op™ Shell or a Sulzer Tibial Baseplate. NOTE: Check ONLY one box. If the APR has been implanted with more than one Affected Product, you must complete a Claim Form for each Affected Product implanted.**

**APR was implanted with a Sulzer Inter-Op™ Shell.**

**OR**

**APR was implanted with a Reprocessed Inter-Op™ Shell.**

**OR**

**APR was implanted with a Sulzer Tibial Baseplate.**

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<sup>1</sup> A CRS is an Affected Product Revision Surgery (“APRS”), a Non-Affected Product Revision Surgery (“NAPRS”), or an Additional Non-Affected Product Revision Surgery (“Additional NAPRS”). An APRS is a surgical removal and/or replacement of an Affected Product for a reason other than trauma. A NAPRS is a surgery (not indicated as a result of trauma) that was performed to remove and/or replace a product that is not an Affected Product within 365 days of an Affected Product Revision Surgery. An Additional NAPRS is a surgery, not the result of trauma, that was performed to remove and/or replace a product that is not an Affected Product after a NAPRS and prior to the date that is eighteen months after the initial Affected Product Revision Surgery with respect to the same hip or knee.

<sup>2</sup> “You” or “your” when used throughout this Claim Form refers to the APR or to the Representative Claimant of the APR.





**If you are a Representative Claimant, you must attach a copy of your court approval or other authorization to represent the APR in this Settlement. Mark the appropriate box below to indicate your previous or current submission of a court approval or authorization:**

- I have provided the requested documentation previously on another form and there is no change.
- A copy of my court approval or other authorization to represent the APR is attached.

**4. ATTORNEY INFORMATION**

Are you represented by an attorney in connection with this claim?

Yes  No

**If “Yes,” you must provide the following information. NOTE: If information previously provided remains current, you may proceed to Question 5.**

\_\_\_\_\_  
(Law Firm Name)

\_\_\_\_\_  
(Attorney’s Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) \_\_\_\_  
(Daytime Area Code & Phone Number) (Evening Area Code & Phone Number)

\_\_\_\_\_  
(Email Address, if any) (Attorney Tax Identification Number)

State the date on which your attorney-client agreement was signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(MM/DD/YYYY)

**NOTE:** A copy of such attorney-client agreement must be attached if you did not previously provide it with your *Blue* or *Orange Form*.

State the total amount of litigation expenses that were incurred in relation to your claim(s): \$ \_\_\_\_\_

**NOTE:** An itemization of all litigation expenses must be attached.

**5. CHANGE IN CONDITION**

If you have qualified for settlement benefits (but not benefits from the EIF) and you subsequently develop a medical condition that qualifies you for EIF benefits, then you have a right to receive additional compensation. You must file a *Green Form* to receive EIF benefits.

If you have previously submitted a *Green Form* and your medical condition worsens and your change places you on a higher Matrix Level, then you have a right to receive incremental payments. To seek additional payment based on a worsened medical condition, you must complete another *Green Form*.



**NOTE:** If this *Green Form* is used to supplement a prior claim, the entire Claim Form does not have to be completed again in full. You need only submit changes to information previously provided. The Physician responsible for completing the “Physician Declaration” should complete only those portions of the form that reflect a change in condition from the condition described in the prior Claim Form(s).

Check the appropriate box below:

- This is an original *Green Form*.  This is a *Green Form* seeking additional compensation for a worsened medical condition.

**6. REQUESTED SUPPLEMENTATION**

If you have submitted a *Green Form* and receive a Tentative Determination Letter or other communication from the Claims Administrator requesting supplemental documentation to support your claim for EIF benefits, you have the right to provide any additional, new documentation or evidence that further supports your claim. All such new documentation must be submitted via cover letter specifying the Sulzer Settlement Claim Number, outlining the new or additional information, and attaching all supporting documentation or evidence.

**NOTE:** Individuals submitting such additional documentation need not submit a new Claim Form for this purpose. A cover letter as indicated above will suffice.

**7. MATRIX LEVELS**

Check each Matrix Level under which you believe you are entitled to compensation from the EIF and then for Questions 8-16, only complete those question(s) that apply to the Matrix Level(s) you check below. For Questions 8-16, do not complete any question(s) for which you do not believe you are entitled to compensation.

- Matrix Level I (Revision Surgery Indicated But For A Medical Condition)
- Matrix Level II (Non-Removal Surgery)
- Matrix Level III (Non-Affected Product Revision Surgery and Additional Non-Affected Product Revision Surgeries)
- Matrix Level IV (Revision Surgery: Major Complication)
- Matrix Level V (Revision Surgery: Permanent Injury)
- Matrix Level VI (Revision Surgery: Myocardial Infarction)
- Matrix Level VII (Revision Surgery: Stroke)
- Matrix Level VIII (Revision Surgery: Death)
- Matrix Level IX (Miscellaneous Complication or Other Harm)

**NOTE:** For all Matrix Levels, you must complete the Medical Authorization Form on the last page of this *Green Form*. For certain Matrix Levels, it is mandatory that you provide a “Physician Declaration” to support your claims. A Physician Declaration Form is included in the *Final Notice Packet*.



**8. MATRIX LEVEL I (Revision Surgery Indicated But For a Medical Condition)**

This question relates to **Matrix Level I** and should be completed only if an Affected Product Revision Surgery (APRS) would be medically contraindicated. If you believe that you qualify for benefits pursuant to **Matrix Level I**, you must provide the following information:

**A. Date the Affected Product was implanted:**  /  /   
(MM/DD/YYYY)

**B. Name and address of hospital of implantation:**

(Hospital Name)

(Street Address)

(City)  (State)  (Zip Code)

(Area Code & Phone Number)  (Fax Area Code & Number)

**C. Implanting surgeon of Affected Product:**

(Surgeon's First Name)  (Middle Initial)  (Last Name)

(Street Address)

(City)  (State)  (Zip Code)

(Area Code & Phone Number)  (Fax Area Code & Number)

**D. Treating surgeon (if different than above) who believes that an APRS would be medically contraindicated:**

(Surgeon's First Name)  (Middle Initial)  (Last Name)

(Street Address)

(City)  (State)  (Zip Code)

(Area Code & Phone Number)  (Fax Area Code & Number)





- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if the Claims Administrator chooses to do so, in order to evaluate your claim.

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. An execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**9. MATRIX LEVEL II (Non-Removal Surgery)**

This question relates only to Matrix Level II and should be completed only if you have undergone a Non-Removal Surgery, wherein your treating surgeon has attempted to secure an Affected Product (for example, by using screws or cement) as a result of non-traumatic loosening. If you believe that you qualify for benefits pursuant to Matrix Level II, you must provide the following information:

**A. How many Non-Removal Surgeries have you undergone?**

- 1       2       3       Other \_\_\_\_\_

**B. For each Non-Removal Surgery, you must provide the following:**

Date of Non-Removal Surgery:    /   /     
(MM/DD/YYYY)

**C. Name and address of hospital where Non-Removal Surgery occurred:**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)      (Zip Code)

(    ) \_\_\_\_\_  
(Area Code & Phone Number)

(    ) \_\_\_\_\_  
(Fax Area Code & Number)

**D. Name and address of surgeon who performed the Non-Removal Surgery:**

\_\_\_\_\_  
(Surgeon's First Name)      (Middle Initial)      (Last Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)      (Zip Code)

(    ) \_\_\_\_\_  
(Area Code & Phone Number)

(    ) \_\_\_\_\_  
(Fax Area Code & Number)

\_\_\_\_\_  
(Reason/Indication for Non-Removal surgery)

**If you required more than one (1) Non-Removal Surgery, check here  and make a copy of this page to provide the additional information and attach it to this Claim Form.**





**C. Hospital where NAPRS occurred:**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State) (Zip Code)

(\_\_\_\_\_)\_\_\_\_\_  
(Area Code & Phone Number)

(\_\_\_\_\_)\_\_\_\_\_  
(Fax Area Code & Number)

**D. Name of surgeon who performed NAPRS:**

\_\_\_\_\_  
(Surgeon's First Name) (Middle Initial) (Last Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State) (Zip Code)

(\_\_\_\_\_)\_\_\_\_\_  
(Area Code & Phone Number)

(\_\_\_\_\_)\_\_\_\_\_  
(Fax Area Code & Number)

\_\_\_\_\_  
(Reason/Indication for NAPRS)

**If you required more than one (1) NAPRS, check here  and make a copy of this page to provide the additional information and attach it to this Claim Form.**

**E. To complete your application for EIF Benefits under Matrix Level III, you must attach the following information:**

- The medical records of the treating surgeon who performed each NAPRS; AND
- The hospital records evidencing each NAPRS that must include, without limitation, a preadmission/admission history and physical examination, an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- A completed "Physician Declaration" from your treating surgeon wherein the physician attests that each NAPRS (for which compensation is sought pursuant to **Matrix Level III**) was not indicated as a result of trauma;<sup>6</sup>

**NOTE:** A completed "Physician Declaration" is only required if the APR's hospital/medical records fail to specifically indicate that the NAPRS and any Additional NAPRS were not indicated as a result of trauma.

AND

- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if the Claims Administrator chooses to do so, in order to evaluate your claim.

<sup>6</sup> The Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified orthopedic surgeon if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating orthopedic surgeon.



**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. An execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**11. MATRIX LEVEL IV (Revision Surgery: Major Complication)**

This question relates only to **Matrix Level IV** and should be completed only if you have suffered a Major Surgical Complication as a result of a Covered Revision Surgery (“CRS”). A CRS is an Affected Product Revision Surgery (“APRS”), a Non-Affected Product Revision Surgery (“NAPRS”), or an Additional Non-Affected Product Revision Surgery (“Additional NAPRS”). An APRS is a surgical removal and/or replacement of an Affected Product for a reason other than trauma. A NAPRS is a surgery, not the result of trauma, that was performed to remove and/or replace a product that is not an Affected Product after a NAPRS and prior to the date that is eighteen months after the initial Affected Product Revision Surgery with respect to the same hip or knee. If you believe that you qualify for benefits pursuant to **Matrix Level IV**, you must provide the following information:

**A. What Major Surgical Complication(s) do you believe have resulted from a CRS?**

- Direct injury to the genito-urinary system during revision;
- Wound infection occurring within 180 days from the date of a CRS and requiring surgical debridement with prosthesis retention, resection arthroplasty, hip arthrodesis or reimplantation;
- (HIP ONLY)** One or more dislocation(s)/subluxation(s) of the prosthetic femoral head occurring within ninety (90) days from the date of a CRS and requiring closed reduction under intravenous sedation or general anesthesia;
- Pulmonary embolism requiring hospitalization and/or placement of an inferior vena cava filter;
- Grade IV heterotopic ossification (as demonstrated on x-ray) and/or heterotopic ossification requiring surgical repair, each occurring on or before 180 days from the date of a CRS;
- (HIP ONLY)** Non-union of a trochanteric osteotomy occurring within 180 days from the date of a CRS and requiring surgical repair;
- (KNEE ONLY)** Non-union of either a tibial tubercle osteotomy occurring within 180 days from the date of a CRS and requiring surgical repair;
- Periprosthetic fracture experienced within thirty (30) days from the date of a CRS and requiring either open or closed reduction;
- (HIP ONLY)** Abductor mechanism disruption occurring within 180 days from the date of a CRS and requiring surgical repair;
- (KNEE ONLY)** Extensor mechanism disruption occurring within 180 days from the date of a CRS and requiring surgical repair; or
- Other: Explain: \_\_\_\_\_





- The hospital records evidencing treatment of each Major Surgical Complication (for which compensation is sought) that should include, but not be limited to (where applicable), a preadmission/admission history and physical examination, an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of the treating surgeon(s) (if different than above) who treated the Major Surgical Complication (for which compensation is sought); AND
- A completed “Physician Declaration” from your treating surgeon wherein he/she causally relates a Major Surgical Complication to a CRS<sup>7</sup>; AND
- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if the Claims Administrator chooses to do so, in order to evaluate your claim.

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. Execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**12. MATRIX LEVEL V (Permanent Injury)**

This section relates only to **Matrix Level V** and should be completed only if you have suffered a Permanent Injury as a result of a CRS (see definition of CRS in Question 11). If you believe that you qualify for benefits pursuant to **Matrix Level V**, you must provide the following information:

**A. What Permanent Injury do you believe that you have suffered as a surgical complication of a CRS?**

- Permanent nerve injury, either moderate or severe, as demonstrated by objective physical examination and quantitative measures (*e.g.*, EMG and/or nerve conduction studies) 365 days after a CRS; or
- Permanent vascular injury, either moderate or severe, as demonstrated by objective physical examination and quantitative measures (*e.g.*, angiogram) 365 days after a CRS; or
- Permanent injury due to an infection (qualifying as a major complication under **Matrix IV**), either moderate or severe, as demonstrated by objective physical examination and quantitative measures 365 days after a CRS; or
- Other: Explain: \_\_\_\_\_

**B. Date on which the CRS that you believe resulted in the Permanent Injury was performed:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

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<sup>7</sup> The Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified orthopedic surgeon if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating orthopedic surgeon.





**H. What is the nature of the Permanent Injury that you believe resulted from a CRS?**

- MODERATE: Pain, sensory loss or gait alteration requiring narcotics and/or use of a cane or walker;
- SEVERE: Pain, sensory loss or gait alteration requiring a wheelchair and/or amputation;
- Other Explain: \_\_\_\_\_

**I. Name and address of all physician(s) who have treated you for the Permanent Injury that you believe resulted from a CRS. Make a copy of this page if you require additional space and attach it to this Claim Form:**

\_\_\_\_\_  
 (Treating Physician's First Name) (Middle Initial) (Last Name)

\_\_\_\_\_  
 (Street Address)

\_\_\_\_\_  
 (City) (State) (Zip Code)

\_\_\_\_\_  
 (Area Code & Phone Number) (Fax Area Code & Number)

**J. To complete your application for EIF Benefits under Matrix Level V, you must attach the following information:**

- The hospital records evidencing each CRS that you believe resulted in a Permanent Injury that must include, without limitation, a preadmission/admission history and physical examination, an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of each treating surgeon who performed a CRS that you believe resulted in a Permanent Injury; AND
- The medical records of the treating surgeon(s) (if different than above) who diagnosed the Permanent Injury that you believe resulted from a CRS; AND
- The hospital records confirming the diagnosis of a Permanent Injury that you believe resulted from a CRS that should include but not be limited to (where applicable) a preadmission/admission history and physical examination, results/reports of all objective quantitative studies performed (EMG, nerve conduction study, angiogram), an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- Hospital records (if different than above) evidencing treatment of the Permanent Injury that you believe resulted from a CRS that should include but not be limited to (where applicable) a preadmission/admission history and physical examination, operative report, operative nursing notes anesthesia records, and a discharge summary; AND
- The medical records of the treating surgeon(s) (if different than above) who treated the Permanent Injury that you believe resulted from a CRS; AND



- A completed “Physician Declaration” from your treating surgeon wherein your physician 1) documents a Permanent Injury (as confirmed by both objective physical signs and quantitative measures 365 days or more after a CRS); 2) describes the nature of the Permanent Injury (*i.e.* whether it is one requiring narcotics, use of a cane, walker, wheelchair or amputation); and 3) causally relates that Permanent Injury to a CRS<sup>8</sup>; AND
- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if the Claims Administrator chooses to do so, in order to evaluate your claim.

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. Execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**13. MATRIX LEVEL VI (Revision Surgery: Myocardial Infarction)**

This question relates only to **Matrix Level VI** and should be completed only if you have suffered a myocardial infarction during a CRS or during the hospitalization associated with a CRS<sup>9</sup> (see definition of CRS in Question 11). If you believe that you qualify for benefits pursuant to **Matrix Level VI**, you must provide the following information:

**A. Date on which the myocardial infarction that you believe was precipitated by a CRS occurred:**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ | \_\_\_\_ | \_\_\_\_ |  
(MM/DD/YYYY)

**B. Date on which the CRS that you believe precipitated the myocardial infarction was performed:**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ | \_\_\_\_ | \_\_\_\_ |  
(MM/DD/YYYY)

**C. Date on which you were discharged from the hospital where the CRS that you believe precipitated your myocardial infarction was performed:**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ | \_\_\_\_ | \_\_\_\_ |  
(MM/DD/YYYY)

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<sup>8</sup> The Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified orthopedic surgeon if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating orthopedic surgeon.

<sup>9</sup> The Claims Administrator may compensate individuals whose treating cardiothoracic surgeon or treating cardiologist causally relates to the CRS a myocardial infarction that did not occur during a CRS or during the hospitalization associated with a CRS.



**D. Name and address of the hospital where the CRS that you believe precipitated your myocardial infarction was performed:**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) --  
(Area Code & Phone Number) (Fax Area Code & Number)

**E. Surgeon who performed the CRS that you believe precipitated your myocardial infarction:**

\_\_\_\_\_  
(Surgeon's First Name) (Middle Initial) (Last Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) --  
(Area Code & Phone Number) (Fax Area Code & Number)

**F. Name and address of the cardiothoracic surgeon(s) and/or cardiologist(s) who diagnosed and treated the myocardial infarction that you believe was precipitated by a CRS:**

\_\_\_\_\_  
(Cardiothoracic Surgeon and/or Cardiologist's Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) --  
(Area Code & Phone Number) (Fax Area Code & Number)

**G. Name and address of the hospital where the myocardial infarction that you believe was precipitated by a CRS was diagnosed and treated:**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

( ) --  
(Area Code & Phone Number) (Fax Area Code & Number)



**H. Check the appropriate box below for the New York Heart Association Functional Class<sup>10</sup> symptoms you had before the myocardial infarction that you believe was precipitated by a CRS:**

- Class I;
- Class II;
- Class III; or
- Class IV

**I. Check the appropriate box below for the New York Heart Association Functional Class<sup>11</sup> symptoms you had after the myocardial infarction that you believe was precipitated by a CRS:**

- Class I;
- Class II;
- Class III; or
- Class IV

**J. To complete your application for EIF benefits under Matrix Level VI, you must attach the following information:**

- The hospital records evidencing the CRS that you believe precipitated your myocardial infarction that should include, but not be limited to, a preadmission/admission history and physical examination, an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of each treating surgeon who performed the CRS that you believe precipitated your myocardial infarction; AND
- The hospital records (if different than above) evidencing treatment of your myocardial infarction that you believe was precipitated by a CRS, that should include, but not be limited to (where applicable), preadmission/admission history and physical examination, operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of the cardiothoracic surgeon(s) and/or cardiologist(s) who diagnosed and treated your myocardial infarction that you believe was precipitated by a CRS; AND

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<sup>10</sup> See T. Andreoli, J. Bennett, C. Carpenter, F. Plum, L. Smith, Jr., *Cecil Essentials of Medicine*, at 12 (3d ed. 1993).

<sup>11</sup> See *id.*



- A completed “Physician Declaration” from a treating cardiothoracic surgeon and/or treating cardiologist wherein the physician documents a 1, 2 or 3 class change in Functional Classification (as defined by the New York Heart Association<sup>12</sup>); AND
- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if the Claims Administrator chooses to do so, in order to evaluate your claim.

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. Execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**14. MATRIX LEVEL VII (Stroke)**

This question relates only to **Matrix Level VII** and should be completed only if you have suffered a stroke during a CRS or during the hospitalization associated with a CRS<sup>14</sup> (see definition of CRS in Question 11). If you believe that you qualify for benefits pursuant to **Matrix Level VII**, you must provide the following information:

**A. Date on which the stroke that you believe was precipitated by a CRS occurred:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

**B. Date on which the CRS that you believe precipitated the stroke was performed:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

**C. Date on which you were discharged from the hospital where the CRS that you believe precipitated your stroke was performed:** \_\_\_\_\_

(MM/DD/YYYY)

**D. Name and address of the hospital where the CRS that you believe precipitated your stroke was performed:\_\_\_\_\_**

\_\_\_\_\_  
(Hospital Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

(\_\_\_\_)\_\_\_\_\_  
(Area Code & Phone Number) (Fax Area Code & Number)

<sup>12</sup> See *id.*

<sup>13</sup> The Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified cardiothoracic surgeon or Board-Certified cardiologist if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating cardiothoracic surgeon and/or a treating cardiologist.

<sup>14</sup> The Claims Administrator may compensate individuals whose treating neurosurgeon or treating neurologist causally relates to the CRS a stroke that did not occur during a CRS or during the hospitalization associated with a CRS.





**I. To complete your application for EIF benefits under Matrix Level VII, you must attach the following information:**

- The hospital records evidencing the CRS that you believe precipitated your stroke that must include, without limitation, a preadmission/admission history and physical examination, an operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of each treating surgeon who performed the CRS that you believe precipitated your stroke; AND
- The hospital records (if different than above) evidencing treatment of your stroke that you believe was precipitated by a CRS, that should include but not be limited to (where applicable), a preadmission/admission history and physical examination, operative report, operative nursing notes, anesthesia records and a discharge summary; AND
- The medical records of the neurosurgeon(s) and/or neurologist(s) who diagnosed and treated your stroke (that you believe was precipitated by a CRS); AND
- A completed “Physician Declaration” from a treating neurosurgeon and/or treating neurologist wherein he/she documents a Functional Stroke Outcome Level of I, II, III or IV (as defined by the American Heart Association Stroke Outcome Classification<sup>16</sup>); AND
- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if he/she chooses to do so, in order to evaluate your claim.

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. Execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

**15. MATRIX LEVEL VIII (Death)**

This question relates only to **Matrix Level VIII** and should only be completed by a Representative Claimant who is submitting this EIF Benefits Claim Form on behalf of an APR who has died during a CRS or whose death was a result of a CRS<sup>18</sup> (see definition of CRS in Question 11). If you believe that you qualify for benefits pursuant to **Matrix Level VIII**, you must provide the following information:

**A. Date on which the death that you believe was caused by a CRS occurred:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

<sup>16</sup> See *id.*

<sup>17</sup> The Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified cardiothoracic surgeon or Board-Certified cardiologist if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating cardiothoracic surgeon or a treating cardiologist.

<sup>18</sup> The Claims Administrator may compensate individuals whose treating physician causally relates the death to the CRS that did not occur during a CRS or during the hospitalization associated with a CRS.







**J. To complete your application for EIF benefits under Matrix Level VIII, you must attach the following information:**

- The hospital records evidencing the CRS (that you believe caused the Death of the APR) that must include, without limitation (where applicable), a preadmission/admission history and physical examination, operative report, operative nursing notes, anesthesia records, discharge/death summary, Certificate of Death, and Autopsy Report; AND
- The medical records of the treating surgeon who performed the CRS that you believe caused the death; AND
- The hospital records (if different than above) for the admission leading up to the APR's death that should include, but not be limited to (where applicable), preadmission/admission history and physical examination, operative report, operative nursing notes, anesthesia records, discharge/death summary, Certificate of Death, and Autopsy Report (if applicable); AND
- Records of the Coroner including Certificate of Death and autopsy findings (if applicable); AND
- A completed "Physician Declaration" from a treating physician wherein he/she causally relates an APR's death to a CRS<sup>19</sup>; AND
- A medical authorization, enabling the Claims Administrator to obtain additional medical records, if he/she chooses to do so, in order to evaluate your claim;

**NOTE:** Medical authorization forms will only be used by the Claims Administrator to verify certain information provided by you. Execution of a medical authorization form does not relieve you of your obligation to provide all of the medical documentation requested herein.

AND

- Documentation confirming a minor or adult child's date of birth which may include a photocopy of his/her birth certificate, Social Security card, or driver's license; AND
- Documentation certifying a parental relationship to the APR; AND
- Documentation (in the form of federal income tax-returns or W-2 statements) that evidence an APR's wages, salaries, or income from self-employment for the 3 years before his/her death.

**16. Matrix Level IX (Miscellaneous Complications or Other Harm)**

This question relates only to **Matrix Level IX** and should only be completed if you believe that you are entitled to receive compensation for complication(s) and/or other harm not anticipated and/or specifically provided for in Questions 8-15. If you believe that you qualify for compensation pursuant to **Matrix Level IX**, you must provide the following information:

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<sup>19</sup> In his/her discretion, the Claims Administrator may accept a Declaration that is prepared by a non-treating, Board-Certified physician if submitted in combination with your affidavit setting forth your attempts to secure a Declaration from a treating physician.







**18. CHANGES TO APR OR REPRESENTATIVE CLAIMANT CONTACT INFORMATION**

Class Members must provide the Claims Administrator updated name, address, and telephone number information in order to ensure processing of their claim. Failure to provide updates may result in termination of a claim or disallowance of benefits. Class Members must include their Sulzer Settlement Claim Number on all correspondence to the Claims Administrator.

**19. WAIVER OF OPT-OUT RIGHTS**

By submitting this form and agreeing to accept benefits pursuant to the Settlement Agreement, the undersigned knowingly waive(s) all Opt-Out Rights provided by the Settlement Agreement, as described in the *Final Notice*, and agree(s) not to object to the Settlement Agreement or to appeal any Court's approval of the Settlement Agreement.

**20. RELEASE AND COVENANT NOT TO SUE**

- a. In consideration of the obligations of Sulzer as set forth in the Settlement Agreement, I, the undersigned Class Member, individually and for my heirs, beneficiaries, agents, estate, executors, administrators, personal representatives, successors and assignees, and/or, if my claim is that of a representative of a person who was implanted with an Affected Product or of the person who has a Derivative Claim arising out of the implantation of the Affected Product, in that capacity, whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, hereby expressly **release and forever discharge and agree not to sue**, Sulzer and all other Released Parties as to all Settled Claims. I understand that certain principles of law provide that a release may not extend to claims that I do not know or suspect to exist. I am aware that I may discover claims presently unknown or unsuspected or facts in addition to or different from those which I now believe to be true with respect to the matters released herein which may be applicable to this Settlement. Despite such principles of law, **I HEREBY KNOWINGLY AND VOLUNTARILY RELINQUISH THE PROTECTIONS OF ALL SUCH FEDERAL OR STATE LAWS, RIGHTS, RULES OR LEGAL PRINCIPLES THAT MAY BE APPLICABLE AS FOLLOWS: I fully, finally, and forever settle and release any and all Settled Claims**, including assigned claims, whether known or unknown, asserted or unasserted, regardless of the legal theory, existing now or arising in the future out of or relating to the purchase, use, manufacture, sale, distribution, promotion, marketing, clinical investigation, administration, regulatory approval, and labeling of an Affected Product **that I may have against any Released Party**.
- b. For purposes of the Release and Covenant Not to Sue, the terms "Settled Claims" and "Released Parties" are defined as set forth in the Settlement Agreement, which is incorporated by reference.
- c. I agree that acceptance of benefits pursuant to the Settlement Agreement settles any lawsuit previously initiated by me, if any, asserting any Settled Claim against Sulzer or any other Released Party, and I stipulate and agree to the dismissal of all such claims, suits and proceedings, with prejudice and without costs and agree to cooperate as reasonably requested in order to effectuate such a dismissal.



**21. CONFIDENTIALITY**

The person(s) signing below hereby consent(s) to the disclosure of the information contained herein to the extent necessary to process claims for benefits pursuant to the Settlement Agreement.

**22. DECLARATION UNDER PENALTY OF PERJURY**

Each person signing below acknowledges and understands that this form is an official document sanctioned by the Court that presides over the legal action entitled *In Re Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation*. Submitting this Claim Form to the Claims Administrator is equivalent to filing it with the Court. After reviewing the information that has been provided on this form, including information, if applicable, that was supplied by a Board-Certified physician and/or an attorney, each person signing this form declares under penalty of perjury that the information provided in this form is true and correct to the best of that person’s knowledge and belief.

\_\_\_\_\_  
(Signature of APR, if living)

\_|\_| / |\_| / |\_|\_|\_|\_|\_|  
(Date MM/DD/YYYY)

\_\_\_\_\_  
(Signature(s) of each Representative Claimant , if any)

\_|\_| / |\_| / |\_|\_|\_|\_|\_|  
(Date MM/DD/YYYY)

\_\_\_\_\_  
(Signature(s) of Derivative Claimant, if any)

\_|\_| / |\_| / |\_|\_|\_|\_|\_|  
(Date MM/DD/YYYY)

Mail this Claim Form and all attachments to:

Claims Administrator  
Sulzer Settlement Trust  
P. O. Box 94558  
Cleveland, Ohio 44101-4558

