# LINCOLN PARK CLASS ACTION BODILY INJURY RESERVE FUND

# CLAIM FORM

## INSTRUCTIONS

To make a claim for a compensation award from the Class Bodily Injury Reserve Fund in *WALTER HINTON, ET AL., Case No. CACE 07 30358 And RAY ADDERLEY, ET AL., Case No. CACE11008499*, you **must** complete this Claim Form and submit the required proof documents (described below) to the Administrator.

To be considered for the Class Bodily Injury Reserve Fund you must be a member of the Property Damage Class or Medical Monitoring Class who is not a named plaintiff in the litigation and who, within a period of one (1) year after the Effective Date, establishes exposure within the Lincoln Park Area of Impact and demonstrates bodily injury associated with exposure to the satisfaction of the Court-Appointed Neutral overseeing the settlement. [If you have not yet registered for the Medical Monitoring Class, you can do so now. Click Register Now on the www.lincolnparksettlement.com main page and register. You have until November 17, 2021]. Examples of eligible injuries the Special Master may consider for payment out of the Bodily Injury Reserve Fund include, but are not limited to, chronic rhinosinusitis, chronic sinusitis, chronic bronchitis, thyroid abnormalities, cancers, kidney disease, certain birth defects, learning impairments, neurological disorders, reproductive disorders, and other respiratory ailments, such as asthma, COPD and sarcoidosis.

The Claim Form and documents must be sent by mail to **Lincoln Park Settlement, c/o Court-Appointed Neutral, 229 South Brevard St., Suite 300, Charlotte, NC 28202**, or by email to team@lincolnparkclaimform.com with a postmark date (for mailing) or transmission date (for email) of no later than **December 9th, 2021.**

Documentation will be required to establish your class membership eligibility, as well as the diagnosis of an eligible injury. You must submit this requested documentation in order for your claim to be considered.

Your responses to this confidential Claim Form will be kept confidential and will only be used to administer benefits in this class action settlement.

When completing this Claim Form, refer to the accompanying Frequently Asked Questions "FAQ" which contains detailed instructions and helpful definitions for completing and submitting the Claim Form. **If you have questions not answered by the FAQ, call 1-855-907-2127.**

## How would you like us to contact you?

We will use this information to determine the best way to contact you regarding your benefits and additional information needed.

I want to receive all future communications from the Administrator in the following language (check only one):

- ❑ English
- ❑ Spanish

I want to receive all future communications from the Administrator in the following manner (check only one):

- ❑ E-Mail
- ❑ Mail

## Class Member Information

We will use this information to contact you regarding your eligibility for benefits and additional information needed. If any of the following information changes, you must promptly notify us by e-mailing team@lincolnparkclaimform.com (or, by mail to Lincoln Park Settlement, c/o Court-Appointed Neutral, 229 South Brevard St., Suite 300, Charlotte, NC 28202).

| | | | |
|---|---|---|---|
| **Name (Required):** | First | Middle Initial | Last |
| **Street Address (Required):** | Street Address | | |
| | Apt. No. | | |
| | City | | |
| | Zip | | |
| **Phone Number:** | | | |
| **Email Address:** | | | |
| **Social Security Number (Required):** | | | |
| **Date of Birth (Required):** | | | |

## Representative Information

Complete below if you are registering as the authorized representative of someone else who is a Class Member. Representatives may include legal guardians of minor Class Members, representatives of estates of deceased Class Members or representatives of legally incompetent Class Members. If you complete this section, all communications from the Administrator will be directed to you as the authorized representative of the Class Member. If any of the following information changes, you must promptly notify us by e-mailing team@lincolnparkclaimform.com (or, by mail to Lincoln Park Settlement, c/o Court-Appointed Neutral, 229 South Brevard St., Suite 300, Charlotte, NC 28202).

| | | | |
|---|---|---|---|
| **Check all that apply to the Class Member for whom you are an authorized representative** | ❑ Minor<br>❑ Person Lacking Capacity or Incompetent Person<br>❑ Deceased Person | | |
| **Relationship to Class Member (e.g. family member)** | | | |
| **Representative Name (Required):** | First | Middle Initial | Last |
| **Street Address (Required):** | Street Address | | |
| | Apt. No. | | |
| | City | | |
| | Zip | | |
| **Phone Number:** | | | |
| **Email Address:** | | | |
| **Documentation Required for Authorized Representatives** | Identify the authority giving you, the authorized representative, the right to act on behalf of the Class Member identified in this Claim Form. You must provide copies of documentation verifying your authority to act, such as a power of attorney or a court order stating your authority to act, or if no such documents are available, documents establishing your legal relationship to the Class Member identified in this Claim Form. | | |

## Attorney Information

The Court has appointed Reginald Clyne of Quintairos, Prieto, Wood & Boyer and Louise Caro of Napoli Shkolnik, PLLC to represent you and other Class Members ("Class Counsel"). You will not be charged by these lawyers for their work on the case. If you want to be represented by a lawyer other than the Court-Appointed Class Counsel referenced above, you may hire one at your own expense.

Complete this section **only if** you are represented by an attorney other than the Court-Appointed Class Counsel in connection with your claim.

**If you complete this section, all communications from the Administrator will be directed to the attorney you identify below, unless your attorney instructs the Administrator otherwise in writing.** If any of the following information changes, you must promptly notify us by e-mailing team@lincolnparkclaimform.com (or, by mail to Lincoln Park Settlement, c/o Court-Appointed Neutral, 229 South Brevard St., Suite 300, Charlotte, NC 28202).

Are you represented by an attorney on than the Court-Appointed Class Counsel in connection with your claim?

- ❑ Yes
- ❑ No

If you answered "yes", please complete the following:

| | | |
|---|---|---|
| **Law Firm Name:** | | |
| **Attorney Name:** | First | Last |
| **Law Firm Mailing Address (Required):** | Street Address | |
| | No. | |
| | City | |
| | Zip | |
| **Attorney Phone Number:** | | |
| **Attorney Email Address:** | | |

# Class Bodily Injury Fund Claim

Were you medically diagnosed with a bodily injury that you claim is associated to exposure to the Lincoln Park Area of Impact (where levels of arsenic, dioxin, and other environmental contaminants may be elevated), such as chronic rhinosinusitis, chronic sinusitis, chronic bronchitis, thyroid abnormalities, cancers, kidney disease, certain birth defects, learning impairments, neurological disorders, reproductive disorders, and / or other respiratory ailments (such as asthma, COPD and sarcoidosis)?

If Yes, describe each bodily injury you were diagnosed with and provide the diagnosis date(s):

- ❑ _____ Diagnosis Date _____ (MM/DD/YYYY)
- ❑ _____ Diagnosis Date _____ (MM/DD/YYYY)
- ❑ _____ Diagnosis Date _____ (MM/DD/YYYY)
- ❑ _____ Diagnosis Date _____ (MM/DD/YYYY)

**Identify any medical insurance that covered that covered your bodily injury referenced above.** (*Check all that apply and complete all data fields, including the full name of the health insurer where applicable)*

| | | |
|---|---|---|
| □ **Medicare** | | |
| □ **Medicaid** | State Medicaid Agency | |
| □ **Private Health Insurance** | Plan Name | Policy Number |
| □ **Veterans Affairs** | Claim Number | |
| | Branch | Treating Facility |
| | Enrollment Start Date | Enrollment End Date |
| | Sponsor | Sponsor's SSN |
| □ **Indian Health Services** | Claim Number | Tribe |

**Did you have any out-of-pocket medical expenses, including any co-pay or deductibles, related to your bodily injury?** (*If so, please provide documents from your health insurance plan or providers detailing the expenses)*

| | | |
|---|---|---|
| □ **Yes** □ **No** | Total Out-of-Pocket Medical Expenses | |

Proof Requirements

FAILURE TO SUBMIT THE REQUIRED DOCUMENTS MAY RESULT IN DELAY OR REJECTION OF YOUR CLAIM

- ❑ Submit medical records sufficient to demonstrate your diagnosis each of the bodily injuries listed above; and
- ❑ Sign and return the Medical Record Authorization Release Form included with this Bodily Injury Claim Form

Please select all the following that apply to you.

- ❑ Resided in Durrs Neighborhood for 10 years or more from anytime as early as 1928 to the present date;
- ❑ Attended Lincoln Park Elementary School, including after-school programs within the school's facilities, anytime between 1960 to 2003;
- ❑ Played in Lincoln Park (while residing in the Durrs Neighborhood for the 10-year exposure period and / or attending Lincoln Park Elementary School) up until the time it was closed for remediation in 2002.

Based on your selection, complete the following detailed information:

| **Resided in the Durrs Neighborhood** | |
|---|---|
| First Date of Residence<br>When did you begin living in the Durrs Neighborhood? Approximate dates are acceptable. | |
| Do you currently still reside in the Durrs Neighborhood?<br>❑ Yes<br>❑ No<br>If you answered "no", please provide the last date that you lived in the Durrs Neighborhood. | |
| Last Date of Residence<br>When did you last live in the Durrs Neighborhood? Approximate dates are acceptable. | |
| Please provide your last residential address in the Durrs Neighborhood. | |
| Street Address (Required): | Street Address |
| | Apt. No. |
| | City |
| | Zip |

| | |
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| Proof Requirements | Class Member must demonstrate proof of residency in the Durrs Neighborhood at any time between 1928 and the present from at least one of the following sources:<br>❑ State-issued identification<br>❑ Utility bills<br>❑ Other types of bills or bank statements or mail addressed to name and address above<br>AND<br>❑ Declaration from Class Member and third party (such as a family member, neighbor, or friend) signed under penalty of perjury that the Class Member resided in the Durrs Neighborhood for a minimum of 10 years. (See www.lincolnparksettlement.com for an example of an acceptable declaration) |

| **Attended Lincoln Park Elementary School** | |
|---|---|
| First Date of Attendance<br>When did you begin attending Lincoln Park Elementary School? Approximate dates are acceptable. | |
| Last Date of Attendance<br>When did you last attend Lincoln Park Elementary School? Approximate dates are acceptable. | |
| Please provide your last residential address while attending Lincoln Park Elementary | |
| Street Address (Required): | Street Address |
| | Apt. No. |
| | City |
| | Zip |
| Proof Requirements | Class Member must demonstrate proof that they attended Lincoln Park Elementary School by submitting at least one of the following:<br>❑ School certificate<br>❑ Photo from yearbook<br>❑ Declaration from Class Member and third party (such as a family member, neighbor, or friend) |

| | |
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| | signed under penalty of perjury that the Class Member attended Lincoln Park Elementary School and/or after care at the school between 1960 and 2003. (See www.lincolnparksettlement.com for an example of an acceptable declaration) |

| **Played in Lincoln Park** | |
|---|---|
| Dates Played in Lincoln Park<br>Approximately when did you play in Lincoln Park? Years are acceptable. | |
| Explain your time in Lincoln Park | |
| Please provide your last residential address during the time you spent playing in Lincoln Park | |
| Street Address (Required): | Street Address |
| | Apt. No. |
| | City |
| | Zip |
| Proof Requirements | Class Member must attest under penalty of perjury that they played in Lincoln Park.<br><br>❑ Declaration from Class Member and third party (such as a family member, neighbor, or friend) signed under penalty of perjury that Class Member played in Lincoln Park up until the time it was closed for remediation in 2002. (See www.lincolnparksettlement.com for an example of an acceptable declaration) |

## Signature

I certify under penalty of perjury pursuant to 28 U.S.C. Section 1746 that the information provided in this Claim Form is true and correct to the best of my knowledge. I understand the Administrator may contact me to request further verification of the information provided in this Claim Form.

Signature of Class Member (or Class Member's Representative)

| Signature: | Date: |
|---|---|
| Print Name: | |

Signature of Attorney of Class Member (if any)

| Signature: | Date: |
|---|---|
| Print Name: | |

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

**(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA," the HIPAA Privacy Rule, and relevant state law)**

TO:_____

Patient Name: _____ DOB: _____ **SSN:**_____

I, _____, hereby authorize you to release and furnish to the Lincoln Park Class Action Settlement Administrator copies of the following information:

- All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires / histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
  All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films /reels, and echocardiogram videos.
- All pharmacy/prescription records including NOC numbers and drug information handouts/monographs. All billing records including all statements, itemized bills, and insurance records.
  The undersigned does not authorize the disclosure of "psychotherapy notes" as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR § 164.501.
- All employment or insurance records.
  All workers' compensation claims or records, including any report of injury, all treatment records, and evidence of any benefits received/paid.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.
4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign his form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I

understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. 45 CFR 164.508. A copy of this authorization may be used in place of an original.

Print Name: _____ (claimant/representative)

Signature: _____ Dated: _____