

MDL-1708 – In re: Guidant Corp. Implantable Defibrillators Products Liability Litigation

MDL SETTLEMENT CONSIDERATION FORM (TO BE FILLED OUT BY CLAIMANTS OR THEIR COUNSEL)

Name _____
First Middle Last

Address _____
Street City State Zip County

Birth date ____/____/____ Social Security # _____

Spouse's Name _____ Spouse's Social Security # _____

If claimant is less than 18 years old OR claimant is deceased:

Parent / Guardian / Deceased's Representative's Name _____
First Last

Address (if diff than above) _____
Street City State Zip

(If applicable) Deceased's date of death: _____

Are you represented by an attorney? Yes No If Yes, attorney name and phone: _____

Name _____

Address _____

Phone/email _____

Device Type (E.g., AVT, Prizm 2 1861, Contak Renewal 1, etc.): _____ Serial Number: _____

(if more than one device) Device Type _____ Serial Number: _____

Date(s) of implantation: _____ Date(s) of explantation (if applicable): _____

Do you contend that you were injured? Yes No If so, were those injuries a result of device malfunction? Yes No If so, please explain when, where and how on the reverse side. In addition, explain what evidence you have (if any) that the device malfunctioned in the manner that caused your device model to be recalled.

Are you claiming any economic losses? Yes No If so, please list them in specific detail on an attached sheet.

If you had an explantation and believe that you suffered unusual physical or emotional complications, please provide a summary sheet of those complications, what costs the complications entailed and also attach any supporting documentation of those complications, including, if appropriate, medical records and bills for medical care. Also, please set forth the basis for any lack of consortium claim. Please note that concerns about an operation are typical, as are such things as bruising, some scarring, slight infections, or having to remain hospitalized or convalesce for a time after an operation.

Do you have health insurance? Yes No Has any such health insurance or other third party insurer or other entity (such an employer or union) paid for any of your claimed expenses? Yes No If "yes," has any of those entities asked you to repay or reimburse them (or asserted a "lien")? Yes No And, if "yes," please identify the name of the entity and the amount of the lien or request for reimbursement or repayment (attach a separate page if necessary):

Did you file a lawsuit? Yes No If "yes," what is the case number and court: _____

If you did not file a lawsuit, what was the date you retained your attorney: _____

All information provided is subject to verification and, in the event it is erroneous, could be subject to penalties of perjury.

The above information is true and correct to the best of my knowledge. _____
Sign on Line Above Print Name Below Date

(NOTE: Verification may be signed by claimant or by claimant's counsel). _____