

Brauer 524(g) Asbestos Trust

- Claim Form for Unliquidated Asbestos Claims -

General Instructions for filing this Claim Form:

This Claim Form should be completed only by holders of Unliquidated Asbestos Claims seeking to liquidate their claims under the Brauer 524(g) Asbestos Trust's (the "Trust") Expedited Review or Individual Review processes as set forth in Section 5.3(a) and (b) of the Brauer 524(g) Asbestos Trust Distribution Procedures (the "TDP").¹

This claim form must be completed as thoroughly as possible to ensure prompt resolution of claims; *submitting an incomplete form may result in delays in processing and/or the Trust not being able to assign the claim a position in the first-in-first-out (FIFO) processing queue.* Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Check the box next to the review election which best suits the injured party's situation:

Expedited Individual Extraordinary Foreign Secondary Exposure

If requesting exigent treatment, check here: Exigent Hardship Exigent Health

Law Firm's matter number for this claim: _____

Section 1: Injured Party Information					
Last Name		First Name		Middle Name	Suffix
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Death (mm/dd/yyyy) (if applicable)	Was death asbestos related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address (if not represented by counsel)					
City	State	Zip	Daytime Telephone		

Section 2: Law Firm / Attorney Information			
Law Firm Name			Electronic Filer ID
Mailing Address			
City	State	Zip Code	
Attorney Last Name	Attorney First Name	Attorney Middle Name	Attorney Suffix
Direct Telephone	Facsimile	E-mail Address	

¹ Capitalized terms used herein and not otherwise defined shall have the meanings assigned to them in the TDP.

Section 3: Asbestos Related Injury

Check the box next to the highest disease level the injured party is claiming.

Disease Level

- Other Asbestos Disease (Level I) Other Cancer (Level II)
- Lung Cancer (Level III) Mesothelioma (Level IV)

Diagnosis Date (mm/dd/yyyy)

If Other Cancer (Level II), please specify malignancy

Section 4: Smoking History (required only for Individual Review Claims for Lung Cancer (Level III))

In the chart below, indicate each period during which the injured party smoked tobacco products and the average number of said products smoked per day.

Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day
Product <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars/Pipes Per Day

Section 5: Personal Representative (if applicable)

Last Name	First Name	Middle Name	Suffix
Social Security Number (optional)	Capacity of Personal Representative (i.e. Administrator, Executor, Guardian, etc.)		
Mailing Address			
City	State	Zip	Daytime Telephone

Section 6: Asbestos Litigation and Claims History

If an asbestos-related lawsuit has ever been filed on behalf of the injured party, please provide the following information.

Filing Date (mm/dd/yyyy)	State	Court	Docket Number
Brauer named as defendant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the injured party ever received settlement monies related to this lawsuit from Brauer or its insurers? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes", amount: \$_____
Jurisdiction Selection If no lawsuit has ever been filed against Brauer on behalf of the injured party, indicate the state elected as the Claimant's Jurisdiction: _____			
Jurisdiction elected is (please check one of the following): <input type="checkbox"/> The state in which the injured party resides when this claim is filed with the Trust. <input type="checkbox"/> A state in which the injured party was allegedly exposed to an asbestos-containing product distributed by Brauer.			
Has a claim on behalf of the injured party ever been submitted to Brauer pursuant to an administrative settlement agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the date of such submission (mm/dd/yyyy): _____			
Was the injured party or claimant a party to a tolling agreement with Brauer? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide the beginning and ending dates, if any, of the tolling and attach documentation of the agreement. Beginning date (mm/dd/yyyy): _____ Ending date (mm/dd/yyyy): _____			

Section 7: Occupational Exposure to Asbestos Products

Provide information below for each location at which the injured party alleges exposure to an asbestos-containing product distributed, installed, maintained or repaired by Brauer or its predecessors. If the duration of the injured party's Brauer Exposure is not sufficient to meet the Significant Occupational Exposure criteria for the Disease Level in question, please provide information regarding other asbestos exposure to satisfy the applicable Significant Occupational Exposure criteria. List each site, industry, and occupation combination separately. Provide the complete name and location of each individual site. Attach additional copies of this page if more space is required.

Part 1

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation		
Site of Exposure (plant or site name)		City	State	Country
Industry in which exposure occurred				
Names of all asbestos-containing products to which injured party was exposed and for which injured party alleges Brauer is legally responsible.				
Description of Significant Occupation Exposure at this jobsite (check all that apply) <input type="checkbox"/> Injured party handled raw asbestos fibers on a regular basis. <input type="checkbox"/> Injured party fabricated asbestos-containing products so that the injured party in the fabrication process was exposed on a regular basis to raw asbestos fibers. <input type="checkbox"/> Injured party altered, repaired, or otherwise worked with an asbestos-containing product such that the injured party was exposed on a regular basis to asbestos fibers. <input type="checkbox"/> Injured party was employed in an industry and occupation such that the injured party worked on a regular basis in close proximity to workers engaged in one or more of the above three activities. <input type="checkbox"/> Other (please describe in as much detail as possible):				

Part 2

If the injured party is filing as an Extraordinary Claim, provide a clear and concise declaration as to how the claim satisfies Section 5.4(a) of the Brauer 524(g) Asbestos Trust Distribution Procedures:

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Section 8: Secondary Exposure

If the injured party's asbestos exposure was solely due to exposure to an occupationally exposed person (OEP), complete Section 7, Part 1 with the exposure information for the OEP and provide the information below.

Date Exposure to OEP Began (mm/dd/yyyy)	Date Exposure to OEP Ended (mm/dd/yyyy)	Relationship to OEP
Description of how injured party was exposed through the OEP to asbestos-containing products distributed, installed, maintained or repaired by Brauer or its predecessors.		

Section 9: Employment / Earnings Information (required only for claims for lost wages or Exigent Hardship Claims based on lost wages)

If economic losses are being claimed, please enclose an economic loss report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status (check all that apply)		
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Retired
<input type="checkbox"/> Partially Disabled	<input type="checkbox"/> Fully Disabled	<input type="checkbox"/> N/A (deceased)
Amount of last annual wages	Date of last wages received (mm/dd/yyyy)	

Section 10: Dependents (not required for Expedited Review)

List injured party's spouse and/or any other dependents.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 2

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 3

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 4

Last Name	First Name	Middle Name	Suffix
Relationship to injured party		Date of Birth (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 11: Certification and Signature

This claim form must be signed by an attorney or, if the injured party is not represented by an attorney, the injured party or the injured party's personal representative.

Upon information and belief, formed after an inquiry reasonable under the circumstances, I hereby certify, under penalty of perjury, that the information submitted is accurate.

Signature of Injured Party, Personal Representative, or Attorney	Date Signed (mm/dd/yyyy)
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Print Name Here

Signatory's Relationship to Injured Party

To file by mail, send this completed form and all supporting documentation to:

Brauer 524(g) Asbestos Trust
c/o Verus Claims Services, LLC
3967 Princeton Pike
Princeton, New Jersey 08540

Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form.

For all claimants:

- Medical records supporting the diagnosis of the claimed Disease Level (see filing instructions for requirements).
- Proof of Brauer Exposure, as set forth in the filing instructions and required by the TDP.

For deceased injured parties:

- Death certificate.

For claims for lost wages or Exigent Hardship Claims based upon lost wages:

- Documentation supporting the claim that any and all wage loss incurred by the injured party was the result of the injured party's asbestos-related disease. This documentation would include, but not be limited to, medical records and/or reports, reports from governmental or insurance agencies and/or reports from the injured party's most recent employer.
- Tax returns and/or W-2 forms for the last three (3) full years of employment.

For Exigent Health Claims:

- Declaration or affidavit by a physician as required by the TDP.

Other supporting documentation, as applicable:

- Letters of Administration or other proof of the personal representative's official capacity (if applicable).
- Copy of tolling agreement (if applicable under Section 6).

If you are filing an Individual Review claim and have additional information (see TDP section 5.3(b)(2)) you would like the Trust to consider in evaluating your claim, please include any related documents or information with the Claim Form.

Payment of Filing Fee:

- The \$20.00 Filing Fee due with respect to this claim has been paid.