

H. K. Porter Asbestos Trust

Proof of Claim Form

General Instructions for filing this Claim Form:

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 may not be able to assign the claim a position in the 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.

Claim Type Election (check all that apply):

- Expedited Non-Expedited Exigent Health

An Exigent Health Claim must provide the following additional documentation:

- (i) documentation that a physician has diagnosed the Claimant as having an asbestos-related illness; and
- (ii) a declaration or affidavit made under penalty of perjury by a physician who has examined the Claimant within one hundred twenty (120) days of the date of the declaration or affidavit in which the physician states, that due to an asbestos disease, there is substantial medical likelihood that the Claimant will not survive six (6) months from the date of the declaration or affidavit.

Claims electing either expedited or non-expedited processing may also elect to defer final processing of the claim until the claimant or his/her representative notifies Verus to change the status from deferred to active. All claim information is still to be submitted now and Verus will still review it for completeness. Only final processing will be deferred.

- Defer final processing of claim

Section 1: Injured Party Information				Firm's Matter Number for this Claim:			
Last Name			First Name		Middle Name		Suffix
Social Security Number or Tax ID		Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Death (mm/dd/yyyy)	Was death asbestos related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mailing Address (last address if deceased)					Daytime Telephone		
City		State	ZIP Code	Country		Spouse	

Section 2: Law Firm / Attorney Information

If the injured party is represented by counsel, please provide the following information:

Law Firm Name				Filer Tax ID		
Mailing Address						
City			State		ZIP Code	
Attorney Last Name		Attorney First Name		Attorney Middle Name		Suffix
Direct Telephone		Facsimile		Email Address		

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Section 3: Asbestos Related Injury

Check the box next to the injury claimed for the injured party, and for which medical documentation is available. *The claim must be supported by appropriate medical documentation as delineated in the H K Porter Medical Criteria.*

Disease Level	
<input type="checkbox"/> Mesothelioma <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Other Cancer <input type="checkbox"/> Non-Malignancy	
Diagnosis Date (mm/dd/yyyy)	If "Other Cancer " selected above, specify the malignancy:

Section 4: Smoking History (Required only for Non-Expedited Review)

Has the injured person ever smoked cigarettes or cigars? Yes No

If "Yes", in the chart below indicate each period during which the injured party smoked tobacco products and the average number of packs or cigars smoked per day. Indicate fractional packs or cigars as decimals (e.g. enter ½ pack per day as 0.5)

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

Section 5: Personal or Estate Representative (if injured party is incompetent or deceased)

Last Name	First Name	Middle Name	Suffix
Social Security Number or Tax ID	Relationship to injured party (<i>Administrator, Executor, Guardian, Brother, Sister, etc.</i>)		
Mailing Address			Daytime Telephone
City	State	ZIP Code	Country

If injured party is incompetent or deceased, complete a Representative Verification form.

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Section 6: Asbestos Litigation and Claims History

Does the Claimant contend that injured party was exposed to asbestos through H. K. Porter products? Yes No

Does Claimant contend that H. K. Porter was negligent and/or negligently failed to inform and/or warn of the risk of exposure to asbestos? Yes No

Has an asbestos-related lawsuit been filed on behalf of the injured party against H. K. Porter or any other asbestos defendant?
 Yes No If "yes", answer the following questions:

File Date (mm/dd/yyyy)	State	Court
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Docket Number	H. K. Porter Named? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Has injured party received settlement monies prior to 1998 from the ACF, H. K. Porter or its insurers? Yes No

If yes, include a copy of the release and enter the amount received: \$_____

If no lawsuit has ever been filed against H. K. Porter on behalf of the injured party, indicate in which state the claimant would have elected to file such suit:	State
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Section 7: Exposure from an Occupationally Exposed Person

Is the claimant alleging an asbestos-related disease for the injured party resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)? Yes No

Date Exposure from Other Person Began (mm/dd/yyyy)	Date Exposure from Other Person Ended (mm/dd/yyyy)	Relationship to Occupationally Exposed Person	SSN of Occupationally Exposed Person
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Description of how injured party was exposed to H.K. Porter Products through Occupationally Exposed Person:

Complete section 8 for the occupationally exposed person.

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Section 8: Occupational Exposure to H. K. Porter Asbestos Materials

Please photocopy this page and use a separate page for each site, industry or occupation in which claimant alleges occupational exposure to H. K. Porter asbestos materials.

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation Code (select from listed below)	If Occupation Code = 30, please specify the occupation:		
If Occupation Code = 30, you must supply a jobsite or jobsites below.					
Site of Exposure (Plant or Site Name)			City	State	Country
Type of H. K. Porter product(s) to which exposed (check all that apply): <input type="checkbox"/> Cloth <input type="checkbox"/> Tape <input type="checkbox"/> Rope <input type="checkbox"/> Yarn <input type="checkbox"/> Felt <input type="checkbox"/> Fiber					
Name of each H. K. Porter company which made product(s) to which person was exposed (check all that apply):					
<input type="checkbox"/> Asbestos Manufacturing Co. (AMCO)		<input type="checkbox"/> Russell Manufacturing Co.		<input type="checkbox"/> Tallman McClusky Fabrics Co.	
<input type="checkbox"/> Carolina Asbestos Co., Inc.		<input type="checkbox"/> Southern Asbestos Co.		<input type="checkbox"/> Thermoid Co.	
<input type="checkbox"/> Pacific Asbestos Corp.		<input type="checkbox"/> Southern Textile Corp.		<input type="checkbox"/> Other / Unknown	

The items in the block below are required only for Non-Expedited Review.

Employer at the plant or site:
Describe how and why H. K. Porter asbestos products were used at this site:
Describe how party was exposed to H. K. Porter product(s):
Description of job duties:

Occupation Codes

- | | | |
|-----------------------------------|---------------------------|------------------------|
| 1. Aluminum manufacturing worker | 12. Industrial carpenter | 23. Refractory worker |
| 2. Asbestos installer | 13. Insulation contractor | 24. Sheetmetal worker |
| 3. Asbestos products manufacturer | 14. Insulator | 25. Shipyard worker |
| 4. Asbestos worker | 15. Ironworker | 26. Steamfitter |
| 5. Boiler cleaner | 16. Machinist | 27. Steel worker |
| 6. Boilermaker | 17. Merchant mariner | 28. Turbine mechanic |
| 7. Brake mechanic | 18. Pipecoverer | 29. Welder |
| 8. Clutch mechanic | 19. Pipefitter | 30. *Other* |
| 9. Commercial laundry worker | 20. Plumber | 31. For Verus use only |
| 10. Electrician | 21. Powerhouse worker | 32. Paper mill worker |
| 11. Foundry worker | 22. Railroad mechanic | 33. Chemical worker |

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Section 9: Employment / Earnings information *(Required only for Non-Expedited Review)*

W-2 and the first page of Form 1040 for the last three years of full employment must be enclosed if lost wages are being claimed.

Current Employment Status (if living):

- Full-time, outside the home Full-time, within the home
 Part-time, outside the home Part-time, within the home
 Retired Disabled

Amount of annual wages for the last full year of employment:

Date of Last Wage Received (mm/dd/yyyy)

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Section 10: Dependents (Required only for Non-Expedited Review)

List any other persons who may have rights associated with this claim. Be sure to include the injured party's spouse, any dependents who derive (or who did derive at the time of the injured person's death) at least one-half of their financial support from the injured party. Also list beneficiaries who are entitled to pursue an action for wrongful death under applicable state law.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Mailing Address			
City	State	ZIP Code	Social Security Number or Tax ID
Relationship to Injured party		Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 2

Last Name	First Name	Middle Name	Suffix
Mailing Address			
City	State	ZIP Code	Social Security Number or Tax ID
Relationship to Injured party		Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent 3

Last Name	First Name	Middle Name	Suffix
Mailing Address			
City	State	ZIP Code	Social Security Number or Tax ID
Relationship to Injured party		Birth Date (mm/dd/yyyy)	Financially Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Section 11: Authorization

This claim form must be signed by the injured party or by the personal or estate representative.

To the best of my knowledge, the information contained in this claim is true and complete and the claimant has not previously relinquished his or her rights to such a claim against the H. K. Porter Company, Inc. or against the H. K. Porter Asbestos Trust.

Signed	Date Signed
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Print Name Here

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

H. K. Porter Asbestos Trust
c/o Verus Claims Services, LLC
57 Hamilton Avenue, Suite 208
Hopewell, NJ 08525

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Section 12: Checklist of Supporting Documentation

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

- The medical evidence required to support the disease claimed in Section 3
- The documents required to support an Exigent Health claim if applicable
- A death certificate if injured party is deceased
- If this Proof of Claim is filed by a personal or estate representative, a Representative Verification form and evidence of representative capacity must be included. Examples of such documents include, but are not limited to:

Living: Power of attorney or guardianship documents

Deceased: Certificate of appointment as an estate representative