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 one):

☐ 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** ☐Male ☐Female	Date of Death (mm/dd/yyyy)	Was death asbestos related? ☐ Yes ☐ No
Mailing Address (last address if deceased)				Daytime Telephone
City	State	ZIP Code	Country	Spouse

Section 2: Law Firm / Attorney Information

If the Claimant 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, including the earliest available with a qualifying diagnosis of the claimed disease.*

Disease Level	
☐ Mesothelioma ☐ Lung Cancer ☐ Other Cancer ☐ 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	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Packs/Cigars Per Day
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			
☐ Cigarettes ☐ Cigars			

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 (*Administrator, Executor, Guardian, Brother, Sister, etc.*)

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

Docket Number	H. K. Porter Named? ☐ Yes ☐ No

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: $_____

For statutes of limitations, enter U.S. state where the injured party incurred exposure to H. K. Porter asbestos.	State

Section 7: Exposure from an Occupationally Exposed Person ("OEP")

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

Occupationally Exposed Person

SSN of Occupationally Exposed Person	Last Name	First Name	Middle Initial

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 = AC, please specify the occupation:

If Occupation Code = AC [Other], 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):

☐ Cloth ☐ Tape ☐ Rope ☐ Yarn ☐ Felt ☐ Fiber ☐ Refractory

Name of each H. K. Porter company which made product(s) to which person was exposed (check all that apply):

☐ Asbestos Manufacturing Co. (AMCO)	☐ Russell Manufacturing Co.	☐ Tallman McClusky Fabrics Co.
☐ Carolina Asbestos Co., Inc.	☐ Southern Asbestos Co.	☐ Thermoid Co.
☐ Pacific Asbestos Corp.	☐ Southern Textile Corp.	☐ 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

A. Asbestos products manufacturing workers
B. Boiler manufacturing and repair workers
C. Carpenters
D. Cement plant workers
E. Chemical and refinery plant production and maintenance workers
F. Drywall and ceiling tile installers
G. Electricians
H. Firefighters
I. Foundry, forge, and heat treating workers
J. Furnace, kiln, oven, drier, and kettle operators and tenders
K. Insulators and pipecovers
L. Laundry and dry-cleaning workers
M. Machinists
N. Maritime: Sailors including commercial and military
O. Mechanics: engines, brakes, and clutches
P. Paper mill production and maintenance workers
Q. Plasterers and stucco masons
R. Plumbers, pipefitters, steamfitters, and HVAC technicians
S. Powerhouse workers
T. Primary metals production and maintenance workers
U. Railroad mechanics
V. Refractory workers
W. Roofers
X. Sheet Metal workers
Y. Shipyard workers doing construction, overhaul, and repair
Z .Stationary engineers and boiler operators
AA. Structural iron and steel workers
AB. Welders
AC. Other
AD. For Verus use only

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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?
		☐ Yes ☐ 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?
		☐ Yes ☐ 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?
		☐ Yes ☐ 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

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
2000 Lenox Drive, Suite 206
Lawrenceville, NJ 08648

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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