

GREEN CLAIM FORM FOR EIF AWARD

This Green Claim Form for Extraordinary Injury Fund (EIF) benefits, along with all requested documentation, must be submitted on or before **September 30, 2014**, to receive **Past** Matrix Level benefits. For **Future** Matrix Level benefits, this Green Claim Form and all requested documentation must be submitted within 90 days of the respective claim's accrual. EIF claims may only be submitted on behalf of Enrolled Program Claimants, including Unrepresented (*Pro Se*) Enrolled Program Claimants, who have undergone an ASR Revision Surgery and who have incurred a specified, unique or extraordinary injury in connection with their ASR Hip Implants, ASR Revision Surgery, or a subsequent Covered Re-Revision Surgery, as set forth in the Part B Award Schedule.

A Claimant submitting this Green Claim Form must also have submitted a qualifying Orange Claim Form for Part A Base Payment.

INSTRUCTIONS

1. Counsel for Claimants, and all *Pro Se* Claimants, who seek compensation for a unique or extraordinary injury in connection with the condition necessitating an ASR Revision Surgery, the ASR Revision Surgery or a subsequent Re-Revision Surgery, as set forth in the Part B Award Schedule, must complete this Green Claim Form.
2. Each Matrix Level section contains a "Summary of Claim" question. In the space provided, explain the basis of the claim and include any information that will assist the Claims Processor's review of the claim.
3. If a Claimant previously submitted a Green Claim Form for EIF benefits, the Claimant is entitled to file a subsequent Green Claim Form for additional compensation if the Product User subsequently develops a medical condition or a change in a medical condition that qualifies the Claimant for additional EIF benefits.
4. As set forth in Section 8.2.6 of the Settlement Agreement, claimants are reminded that there are no depositions, no written discovery, no expert reports, affidavits, or hearings or trials in connection with the filing of PART B claims or the evaluation or determination of any PART B Awards. QUSCs have the burden of proof and burden of production with respect to the contemporaneous Medical Records submitted in the Claims Package and any additional contemporaneous Medical Records of such QUSC submitted for establishing that the criteria has been met for any PART B Award.

Notwithstanding the above admonition, pursuant to Section 4.1.5 of the Settlement Agreement, Claimants may submit additional documentation (including, but not limited to, tax returns, W-2 statements) for the limited purpose of proving lost wages or loss of earnings under Matrix Levels VI and VII.

5. If this Green Claim Form is used to supplement a prior claim, the entire Claim Form need not be completed again in full. Only changes to information previously provided need to be submitted. Indicate below whether this is an original Green Claim Form (*i.e.*, the first Green Claim Form that has been submitted on behalf of a Claimant) or a supplemental Green Claim Form (*i.e.*, a Green Claim Form that a Claimant is submitting to apply for additional benefits from the EIF matrices).

This is an Original Claim Form.

This is a Supplemental EIF Benefits Claim Form.

A. PERSONAL INFORMATION OF PRODUCT USER

1. Name	<small>Last</small> DOE	<small>First</small> JANE	<small>Middle Initial</small> L.
2. Social Security Number	9 8 7 - 7 9 - 9 1 9 8	3. Date of Birth	<u>11/27/1969</u> <small>(MM/DD/YYYY)</small>

B. PRIMARY LAW FIRM INFORMATION (if represented by an attorney)

4. Principal Responsible Attorney	<small>Last</small> SMITH	<small>First</small> JOHN	<small>Middle Initial</small> Initial
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5. Firm Name	Law Firm 1		
6. Current Address	Street		
	City	State	Zip

C. EIF MATRIX LEVELS

Check each Matrix Level under which the QUSC believes he/she is entitled to compensation.

Matrix Levels		Matrix Type	
		Past	Future
I.	Re-Revision Surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>
II.	Major Complication – Pulmonary Embolism or Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>
	Major Complication – Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
	Major Complication – Foot Drop	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Major Complication – Infection	<input type="checkbox"/>	<input type="checkbox"/>
	Major Complication – Miscellaneous Major Complication	<input type="checkbox"/>	<input type="checkbox"/>
III.	Delayed Recovery – Foot Drop	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Delayed Recovery – Infection	<input type="checkbox"/>	<input type="checkbox"/>
	Delayed Recovery – Miscellaneous	<input type="checkbox"/>	<input type="checkbox"/>
IV.	Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
V.	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
VI.	Death	<input type="checkbox"/>	<input type="checkbox"/>
VII.	Miscellaneous Discretionary	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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To complete an application for EIF Benefits, a QUSC must complete this Green Claim Form including all designated sections for the requested Matrix Level and Matrix Type. Additionally, a QUSC must have already completed the following:

- The Orange Claim Form for Part A Base Benefits (along with all necessary attachments); and
- The Blue Claim Form for Lien Resolution.

D. MATRIX LEVEL I (Re-Revision Surgery)

This section relates only to **Matrix Level I – Re-Revision Surgery** and should be completed only if a QUSC has undergone a Re-Revision Surgery that meets the following criteria:

1. The Re-Revision involved removal of the cup of a hip device implanted in the QUSC during his/her ASR Revision Surgery or Bilateral ASR Revision Surgery on the same hip or during a subsequent Re-Revision Surgery on the same hip following the ASR Revision Surgery or Bilateral ASR Revision Surgery; and
2. The Re-Revision was not necessitated by trauma (as defined in Section 1.2.35).

To submit a claim for **PAST Matrix Level I**, the QUSC must have undergone Re-Revision Surgery before April 1, 2014. To submit a claim for **FUTURE Matrix Level I**, on or after April 1, 2014, the QUSC must undergo Re-Revision Surgery on or before the date that is: (1) on or before 547 days after another Covered Re-Revision Surgery; and (2) on or before the date that is two years from the date of the ASR Revision Surgery on that hip. An award under this Future Matrix Level I shall be calculated in the same manner and subject to the same limitations and reductions as an award under the Past Matrix Level I, except that the Future Matrix Level I award will be subject to a reduction of up to 75%.

If a Product User has had more than one Re-Revision Surgery, make copies of this Section D for each Re-Revision Surgery and attach them to the signed Claim Form. The maximum number of compensable Re-Revisions under this Matrix Level I shall be three per hip in which an ASR Hip Implant has been removed. Additional Re-Revisions may, at the discretion of the Team and the SOC, be compensable under Matrix Level VII.

1. Matrix Type	<input checked="" type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Affected Hip	<input type="checkbox"/> Left <input checked="" type="checkbox"/> Right	3. Re-Revision Surgery Date	<u>4 / 4 / 2012</u> <small>(MM/DD/YYYY)</small>
4. Name of Hospital where Re-Revision Surgery Occurred	Santa Fe General Hospital		
5. Surgeon Name	Last	First	Middle Initial
	JONES	BOB	
6. Reason for Re-Revision Surgery	Acetabular cup loosened.		
7. Summary of Claim	Ms. Doe underwent an Index Surgery on her right hip on 2/2/10 and received a total hip replacement with an ASR XL Hip Implant. The acetabular cup loosened and Ms. Doe had a Revision Surgery on 3/3/11, during which Dr. Jones removed the cup and replaced it with a Pinnacle acetabular cup system. The Pinnacle acetabular cup subsequently loosened and Ms. Doe underwent a Re-Revision Surgery on 4/4/12.		

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When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level I – Re-Revision Surgery, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the treating surgeon who performed each Re-Revision Surgery; and
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to any Re-Revision Surgery.

E. MATRIX LEVEL II (Major Complications): Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)

This section relates only to **Matrix Level II – Major Complications: PE or DVT** and should be completed only if a QUSC suffers either a pulmonary embolism (“PE”) (an obstruction of an artery in the lungs caused by a blood clot), or deep vein thrombosis (“DVT”) (condition in which a blood clot forms in one or more of the veins in the legs or pelvis) that meets the following criteria:

1. The PE or DVT was diagnosed during the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery; and
2. The QUSC required additional hospitalization for treatment of the PE or DVT.

A QUSC who suffers and was diagnosed with a pulmonary embolism or deep vein thrombosis in close temporal proximity to (in no event greater than 60 days), but following, the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery, may be entitled to an award under this Section based upon a process to be determined by the Team and the SOC at a later date provided that the ASR Revision Surgery or Covered Re-Revision Surgery was a cause of the PE or DVT.

To submit a claim for **PAST Matrix Level II – Major Complications: PE or DVT**, the QUSC must have suffered a PE or DVT before April 1, 2014. To submit a claim for **FUTURE Matrix Level II – Major Complications: PE or DVT**, the QUSC must suffer a PE or DVT on or after April 1, 2014, but within two years of the ASR Revision Surgery. An award under this Future Matrix Level II shall be calculated in the same manner and subject to the same qualifications, reductions and limitations as an award under the Past Matrix Level II, except that the Future Matrix Level II award will be subject to a reduction of up to 75%.

If a Product User has had more than one Major Complication: Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT), make copies of this Section E for each PE or DVT and attach them to the signed Claim Form. The maximum number of compensable PEs and/or DVTs shall be two.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Complication Type	<input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Deep Vein Thrombosis		
3. Diagnosis Date	____/____/____ (MM/DD/YYYY)	4. Treatment Date	____/____/____ (MM/DD/YYYY)
5. Name of Hospital where PE or DVT was Diagnosed or Treated			
6. Name of Diagnosing/ Treating Physician	Last	First	Middle Initial

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7. Summary of Claim

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level II – Major Complications: PE or DVT, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the treating physician who treated each PE and/or DVT; and
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries, Radiology or Imaging Reports and Operative Records pertaining to any PE or DVT.

F. MATRIX LEVEL II (Major Complications): Dislocation

This section relates only to **Matrix Level II- Major Complications: Dislocation** and should be completed only if a QUSC suffers one or more dislocations of the prosthetic femoral head of the hip that underwent an ASR Revision Surgery, as documented in contemporaneous medical records, and who underwent a closed reduction in a hospital or an open reduction in a hospital.

To submit a claim for **PAST Matrix Level II – Major Complications: Dislocation**, the QUSC must have suffered a dislocation before April 1, 2014. To submit a claim for **FUTURE Matrix Level II – Major Complications: Dislocation**, the QUSC must suffer a dislocation on or after April 1, 2014, and on a date that is: (1) on or before 365 days after a Covered Re-Revision Surgery; and (2) within two years of the ASR Revision Surgery on that hip. An award under this Future Matrix Level II shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level II, except that the Future Matrix Level II award will be subject to a reduction of up to 75%.

If a Product User has had more than one Major Complication: Dislocation, make copies of this Section F for each Dislocation and attach them to the signed Claim Form. The maximum number of compensable dislocations shall be three per hip in which the cup of an ASR Hip Implant had been removed.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)	2. Affected Hip	<input type="checkbox"/> Left <input type="checkbox"/> Right
3. Date of Dislocation	____/____/____ (MM/DD/YYYY)	4. Treatment Type	<input type="checkbox"/> Open Reduction <input type="checkbox"/> Closed Reduction
5. Had the Product User experienced two or more dislocations of the Affected Hip identified in Question 2 of this section before the ASR Index Surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, complete Item 6. If No, skip to Item 7.
6. If Yes, provide a brief explanation.			
7. Did the claimant experience any trauma to the Affected Hip after the ASR Revision Surgery and before this dislocation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, complete Item 8. If No, skip to Item 9.
8. If Yes, provide a brief explanation.			
9. Name of Hospital where Dislocation was Diagnosed or Treated			

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10. Name of Diagnosing/ Treating Physician	Last	First	Middle Initial
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11. Summary of Claim	
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When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level II – Major Complications: Dislocations, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the treating surgeon who treated each Dislocation; and
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to any dislocation.

G. MATRIX LEVEL II (Major Complications): Foot Drop

This section relates only to **Matrix Level II- Major Complications: Foot Drop** and should be completed only if, a QUSC has suffered an injury to the peroneal nerve as a result of the ASR Revision Surgery or a Covered Re-Revision Surgery, resulting in the inability to lift the front part of the foot and where the following criteria are met:

1. The foot drop is manifested through objective physical examination during the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery, as documented in contemporaneous medical records; and
2. The foot drop is ultimately diagnosed as a peroneal nerve injury and continues to manifest itself 90 days after the ASR Revision Surgery or a Covered Re-Revision Surgery – Past or Future.

To submit a claim for **PAST Matrix Level II – Major Complications: Foot Drop**, a QUSC must have suffered a foot drop before April 1, 2014. To submit a claim for **FUTURE Matrix Level II – Major Complications: Foot Drop**, a QUSC must suffer a foot drop on or after April 1, 2014, and within two years of the ASR Revision Surgery on that hip. An award under this Future Matrix Level II shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level II, except that the Future Matrix Level II award will be subject to a reduction of up to 75%.

If a Product User has had more than one Major Complication: Foot Drop, make copies of this Section G for each instance of Foot Drop and attach them to the signed Claim Form. A QUSC can receive only one Matrix Level II award due to Foot Drop, regardless of the number of instances of Foot Drop, and a QUSC who is eligible for Matrix Level II and Matrix Level III benefits related to Foot Drop will receive the greater of the two awards.

1. Matrix Type	<input checked="" type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)	2. Affected Hip	<input type="checkbox"/> Left <input checked="" type="checkbox"/> Right
3. Date Foot Drop First Manifested	<u>4 / 8 / 2012</u> (MM/DD/YYYY)	4. Date of Diagnosis	<u>4 / 21 / 2012</u> (MM/DD/YYYY)
5. Does the Foot Drop continue to manifest?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		If No, complete Item 6. If Yes, skip to Item 7.	
6. If No, provide the date of the last manifestation.		<u>8 / 3 / 2013</u> (MM/DD/YYYY)	
7. Name of Hospital where Foot Drop was Diagnosed or Treated	Santa Fe General Hospital		

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8. Name of Diagnosing/ Treating Physician	Last JONES	First BOB	Middle Initial
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9. Summary of Claim	Ms. Doe suffered a foot drop, which Dr. Jones diagnosed on 4/8/12 while Ms. Doe was hospitalized for her Re-Revision Surgery. On 4/21/12, Dr. Jones informed Ms. Doe that the foot drop was the result of a peroneal nerve injury.
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When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level II – Major Complications: Foot Drop, a QUSC must submit these documents:

A true and correct copy of all contemporaneous Medical Records from the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery documenting the manifestation of a foot drop through objective physical examination;

A true and correct copy of all contemporaneous Medical Records of the treating physician or surgeon who diagnosed and/or managed the foot drop or peroneal nerve injury; and

A true and correct copy of all contemporaneous Medical Records showing the foot drop continued to manifest for 90 days or more.

H. MATRIX LEVEL II (Major Complications): Infection

This section relates only to **Matrix Level II- Major Complications: Infection** and should be completed only if a QUSC has undergone one of the following treatments for infection related to ASR Revision Surgery:

1. Eight (8) weeks (defined as 56 days) of continuous intravenous antibiotic treatment; or
2. An open surgical procedure with prosthesis retention (e.g., debridement and/or insertion of antibiotic beads); or
3. Where the QUSC was implanted with an antibiotic spacer.

A QUSC who receives IV antibiotics for ≥ 6 continuous weeks but less than 8 continuous weeks may, at the discretion of the Team and the SOC, receive compensation under Matrix Level VII.

To submit a claim for **PAST Matrix Level II – Major Complications: Infection**, a QUSC must have been treated for the infection before April 1, 2014. To submit a claim for **FUTURE Matrix Level II – Major Complications: Infection**, a QUSC must be treated for the infection on or after April 1, 2014, that is related to a Re-Revision Surgery on or before the date that is: (1) 547 days after an ASR Revision Surgery or Covered Re-Revision Surgery; and (2) within two years from the date of the ASR Revision Surgery. An award under this Future Matrix Level II shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level II, except that the Future Matrix Level II award will be subject to a reduction of up to 75%.

If a Product User has had more than one Major Complication: Infection, make copies of this Section H for each Infection and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level II award (the greater of which applies) due to Infection, regardless of the length or number of infections claimed. A QUSC who receives a Matrix Level II award due to Infection may additionally qualify to receive a Matrix Level III award.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)
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2. Date of Diagnosis	____/____/____ (MM/DD/YYYY)
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3. Was the Product User treated for or diagnosed with infection in the Affected Hip between the time of the Index Surgery and the ASR Revision Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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4. If you answered Yes to Question 3, provide the date(s) of treatment or diagnosis.	____/____/____ (MM/DD/YYYY)						
5. Was the Product User treated for or diagnosed with infection at the time of the ASR Revision Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
6. Name of Hospital where Infection was Diagnosed or Treated							
7. Name of Diagnosing/ Treating Physician	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;"><small>Last</small></td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;"><small>First</small></td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center;"><small>Middle Initial</small></td> </tr> <tr> <td style="height: 30px;"></td> <td></td> <td></td> </tr> </table>	<small>Last</small>	<small>First</small>	<small>Middle Initial</small>			
<small>Last</small>	<small>First</small>	<small>Middle Initial</small>					
8. Summary of Claim							

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level II – Major Complications: Infection, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records from the ASR Revision Surgery Hospitalization including, but not limited to, records from pathology/histopathology, labs/chemistry, radiology, physicians’ notes, and discharge summaries;
- A true and correct copy of all contemporaneous Medical Records of the treating physician who treated each Infection; and
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to an Infection.

I. MATRIX LEVEL II (Major Complications): Miscellaneous Major Complication

This section relates only to **Matrix Level II – Major Complications: Miscellaneous Major Complication** and should be completed only if a QUSC has suffered a Major Complication not enumerated (in 1-4, above) and where the Major Complication was directly related to the reason necessitating, or directly arising from, an ASR Revision Surgery or Covered Re-Revision Surgery.

To submit a claim for **PAST Matrix Level II – Major Complications: Miscellaneous Major Complication**, the QUSC must have suffered a major complication before April 1, 2014. To submit a claim for a **FUTURE Matrix Level II – Major Complications: Miscellaneous Major Complication**, the QUSC must suffer a major complication on or after April 1, 2014, but within two years of the ASR Revision Surgery on that hip.

If a Product User has had more than one Major Complication: Miscellaneous Major Complication, make copies of this Section I for each Miscellaneous Major Complication and attach them to the signed Claim Form.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)
2. Date of Diagnosis	____/____/____ (MM/DD/YYYY)
3. Description of Complication	

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4. Name of Hospital where Complication was Diagnosed or Treated			
5. Name of Diagnosing/ Treating Physician	Last	First	Middle Initial
6. Summary of Claim			

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level II – Major Complications: Miscellaneous Major Complication, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the treating physician or surgeon who diagnosed and/or managed each Miscellaneous Major Complication; and
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the Miscellaneous Major Complication.

J. MATRIX LEVEL III (Delayed Recovery): Foot Drop

This section relates only to **Matrix Level III – Delayed Recovery: Foot Drop** and should be completed only if a QUSC suffered foot drop (a peroneal nerve injury qualifying as a Major Complication under Matrix Level II) that is documented in contemporaneous medical records as continuing to exist on the date that is 365 days after an ASR Revision Surgery or Covered Re-Revision Surgery.

To submit a claim for **PAST Matrix Level III – Delayed Recovery: Foot Drop**, a QUSC must have suffered a foot drop before April 1, 2014. To submit a claim for **FUTURE Matrix Level III – Delayed Recovery: Foot Drop**, a QUSC must suffer a foot drop on or after April 1, 2014 and within two years of an ASR Revision Surgery. An award under this Future Matrix Level III shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level III, except that the Future Matrix Level III award will be subject to a reduction of up to 75%.

If a Product User has had more than one instance of Delayed Recovery: Foot Drop, make copies of this Section J for each instance and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level III award that is between \$34,000 and \$288,000 and based on the QUSC's age on the date of his/her first ASR Revision Surgery and the defined severity level. A QUSC who is eligible for Matrix Level II and Matrix Level III benefits related to Foot Drop will receive the greater of the two awards.

1. Matrix Type	<input checked="" type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Nature of Delayed Recovery	<input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Severe		
3. Date Injury Forming the Basis of the Delayed Recovery Claim First Manifested	<u>4 / 8 / 2012</u> <small>(MM/DD/YYYY)</small>	4. Date of Original Injury	<u>4 / 21 / 2012</u> <small>(MM/DD/YYYY)</small>
5. Did the Product User require the use of crutches, a cane, or walker before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
6. Did the Product User require the use of a wheelchair before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

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7. Did the Product User require the daily use of prescription pain medication before the implantation of the ASR Hip Implant?

Yes

No

8. If Yes to Questions 5, 6 or 7, provide the timeframe and describe the circumstances.

9. Name of Physician Diagnosing and/or Treating the Injuries Forming the Basis of the Delayed Recovery Claim

Last

JONES

First

BOB

Middle Initial

10. Summary of Claim

Ms. Doe suffered a foot drop, which Dr. Jones diagnosed on 4/8/12 while Ms. Doe was hospitalized for her Re-Revision Surgery. On 4/21/12, Dr. Jones informed Ms. Doe that the foot drop was the result of a peroneal nerve injury. On 6/14/12, Ms. Doe was instructed to use a cane or other supportive walking device for all activities where she would be on her feet for a period of time exceeding 20-30 minutes in length while she recovered. Ms. Doe last visited Dr. Jones on 8/3/13 in connection with this injury.

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level III – Delayed Recovery: Foot Drop, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records from the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery documenting the manifestation of the Delayed Recovery injury;
- A true and correct copy of the contemporaneous Medical Records of the treating physician or surgeon who diagnosed and/or managed the Delayed Recovery injury;
- A true and correct copy of all contemporaneous Medical Records showing that the injury forming the basis of the Delayed Recovery claim continued to manifest for 365 or more days after an ASR Revision Surgery or Covered Re-Revision Surgery;
- If the nature of the Delayed Recovery is moderate, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) experiences pain requiring a daily use of prescription pain medication or (2) has a gait alteration requiring the use of crutches, a cane or walker for a substantial portion of activities of daily living; and
- If the nature of the Delayed Recovery is severe, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) requires the use of a wheelchair for a substantial portion of activities or (2) underwent an amputation.

K. MATRIX LEVEL III (Delayed Recovery): Infection

This section relates only to **Matrix Level III – Delayed Recovery: Infection** and should be completed only if a QUSC suffered an injury due to an infection (qualifying as a Major Complication under Matrix Level II) that is documented in contemporaneous medical records as continuing to exist on or after the date that is 365 days after the diagnosis of the Qualifying Infection.

To submit a claim for **PAST Matrix Level III – Delayed Recovery: Infection**, a QUSC must have suffered an infection before April 1, 2014. To submit a claim for **FUTURE Matrix Level III – Delayed Recovery: Infection**, a QUSC must suffer an infection on or after April 1, 2014 and within two years of an ASR Revision Surgery. An award under this Future Matrix Level III shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level III, except that the Future Matrix Level III award will be subject to a reduction of up to 75%.

If a Product User has had more than one instance of Delayed Recovery: Infection, make copies of this Section K for each instance and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level III award that is between \$34,000 and \$288,000 and based on the QUSC's age on the date of his/her first ASR Revision Surgery and the defined severity level. A QUSC who is eligible for Matrix Level II and Matrix Level III benefits related to Infection will receive the greater of the two awards.

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1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Nature of Delayed Recovery	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
3. Date Injury Forming the Basis of the Delayed Recovery Claim First Manifested	____/____/____ (MM/DD/YYYY)	4. Date of Original Injury	____/____/____ (MM/DD/YYYY)
5. Did the Product User require the use of crutches, a cane, or walker before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Did the Product User require the use of a wheelchair before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Did the Product User require the daily use of prescription pain medication before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8. If Yes to Questions 5, 6 or 7, provide the timeframe and describe the circumstances.			
9. Name of Physician Diagnosing and/or Treating the Injuries Forming the Basis of the Delayed Recovery Claim	Last	First	Middle Initial
10. Summary of Claim			
When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level III – Delayed Recovery: Infection, a QUSC must submit these documents:			
<input type="checkbox"/> A true and correct copy of all contemporaneous Medical Records from the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery documenting the manifestation of the Delayed Recovery injury;			
<input type="checkbox"/> A true and correct copy of the contemporaneous Medical Records of the treating physician or surgeon who diagnosed and/or managed the Delayed Recovery injury;			
<input type="checkbox"/> A true and correct copy of all contemporaneous Medical Records showing that the injury forming the basis of the Delayed Recovery claim continued to manifest for 365 or more days after an ASR Revision Surgery or Covered Re-Revision Surgery;			
<input type="checkbox"/> If the nature of the Delayed Recovery is moderate, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) experiences pain requiring a daily use of prescription pain medication or (2) has a gait alteration requiring the use of crutches, a cane or walker for a substantial portion of activities of daily living; and			
<input type="checkbox"/> If the nature of the Delayed Recovery is severe, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) requires the use of a wheelchair for a substantial portion of activities or (2) underwent an amputation.			

GREEN CLAIM FORM FOR EIF AWARD

L. MATRIX LEVEL III (Delayed Recovery): Miscellaneous

This section relates only to **Matrix Level III – Delayed Recovery: Miscellaneous** and should be completed only if a QUSC suffered a Miscellaneous Injury (qualifying as a Miscellaneous Major Complication under Matrix Level II) that is documented in contemporaneous medical records as continuing to exist on the date that is 365 days after an ASR Revision Surgery or Covered Re-Revision Surgery.

To submit a claim for **PAST Matrix Level III – Delayed Recovery: Miscellaneous**, a QUSC must have suffered a miscellaneous injury before April 1, 2014. To submit a claim for **FUTURE Matrix Level III – Delayed Recovery: Miscellaneous**, a QUSC must suffer a miscellaneous injury on or after April 1, 2014 and within two years of an ASR Revision Surgery. An award under this Future Matrix Level III shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level III, except that the Future Matrix Level III award will be subject to a reduction of up to 75%.

If a Product User has had more than one instance of Delayed Recovery: Miscellaneous, make copies of this Section L for each instance and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level III award that is between \$34,000 and \$288,000 and based on the QUSC's age on the date of his/her first ASR Revision Surgery and the defined severity level.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Nature of Delayed Recovery	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
3. Date Injury Forming the Basis of the Delayed Recovery Claim First Manifested	<div style="text-align: center;"> ____/____/____ (MM/DD/YYYY) </div>	4. Date of Original Injury	<div style="text-align: center;"> ____/____/____ (MM/DD/YYYY) </div>
5. Did the Product User require the use of crutches, a cane, or walker before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Did the Product User require the use of a wheelchair before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Did the Product User require the daily use of prescription pain medication before the implantation of the ASR Hip Implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
8. If Yes to Questions 5, 6 or 7, provide the timeframe and describe the circumstances.			
9. Name of Physician Diagnosing and/or Treating the Injuries Forming the Basis of the Delayed Recovery Claim	Last	First	Middle Initial
10. Summary of Claim			

GREEN CLAIM FORM FOR EIF AWARD

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level III – Delayed Recovery: Miscellaneous, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records from the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery documenting the manifestation of the Delayed Recovery injury;
- A true and correct copy of the contemporaneous Medical Records of the treating physician or surgeon who diagnosed and/or managed the Delayed Recovery injury;
- A true and correct copy of all contemporaneous Medical Records showing that the injury forming the basis of the Delayed Recovery claim continued to manifest for 365 or more days after an ASR Revision Surgery or Covered Re-Revision Surgery;
- If the nature of the Delayed Recovery is moderate, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) experiences pain requiring a daily use of prescription pain medication or (2) has a gait alteration requiring the use of crutches, a cane or walker for a substantial portion of activities of daily living; and
- If the nature of the Delayed Recovery is severe, a true and correct copy of all contemporaneous Medical Records showing that, at 365 or more days, the claimant (1) requires the use of a wheelchair for a substantial portion of activities or (2) underwent an amputation.

M. MATRIX LEVEL IV (Myocardial Infarction)

This section relates only to **Matrix Level IV (Myocardial Infarction)** and should be completed only if a QUSC has suffered a myocardial infarction (i) during the ASR Revision Surgery or Covered Re-Revision Surgery, or (ii) during the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery (Section 8.4.13). A QUSC will receive an award under this section based upon (a) the pre- and post- myocardial infarction change in Functional Classification (as defined by the New York Heart Association) and (b) the QUSC's age on the date of the myocardial infarction, according to the PART B Award Schedule (Section 8.4.13.2). QUSCs who suffered a myocardial infarction in close temporal proximity to (in no event greater than 30 days), but following, the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery may be entitled to an award under this Section, based upon a process to be determined by the Team and the SOC at a later date, provided that the ASR Revision Surgery or Covered Re-Revision Surgery was a cause of the myocardial infarction (Section 8.4.13.1.1).

To submit a claim for **PAST Matrix Level IV – Myocardial Infarction**, a QUSC must have suffered a myocardial infarction before April 1, 2014. To submit a claim for **FUTURE Matrix Level IV – Myocardial Infarction**, a QUSC must suffer a myocardial infarction on or after April 1, 2014 and within two years of an ASR Revision Surgery. An award under this Future Matrix Level IV shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level IV, except that the Future Matrix Level IV award will be subject to a reduction of up to 50%.

If a Product User has had more than one Myocardial Infarction, make copies of this Section M for each MI and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level IV award, regardless of the number, type, or location of myocardial infarctions suffered, that is between \$66,000 and \$360,000 and based on the pre- and post-myocardial infarction change in Functional Classification (as defined by the New York Heart Association) and the QUSC's age on the date of the myocardial infarction.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)
2. Date of Myocardial Infarction (MI)	____/____/____ (MM/DD/YYYY)
3. Date of Surgery that Precipitated MI	____/____/____ (MM/DD/YYYY)
4. Date of Discharge from Surgery	____/____/____ (MM/DD/YYYY)

GREEN CLAIM FORM FOR EIF AWARD

5. New York Heart Association Functional Class Symptoms <u>BEFORE</u> the MI	<input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV <input type="checkbox"/> N/A						
6. New York Heart Association Functional Class Symptoms <u>AFTER</u> the MI	<input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV						
7. Does the Product User have a history of cardiac problems, and/or had the Product User consulted with a cardiologist and/or cardiothoracic surgeon before the MI?	<input type="checkbox"/> Yes <input type="checkbox"/> No <div style="text-align: right; font-size: small;"> If Yes, complete Item 8. If No, skip to Item 9. </div>						
8. If Yes, provide a brief description and Name of the consulting physician(s):							
9. Name of Hospital where MI was Diagnosed or Treated							
10. Name of Diagnosing/ Treating Cardiothoracic Surgeon or Cardiologist	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; font-size: x-small;">Last</td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; font-size: x-small;">First</td> <td style="width: 33%; border-bottom: 1px solid black; text-align: center; font-size: x-small;">Middle Initial</td> </tr> <tr> <td style="height: 40px;"></td> <td></td> <td></td> </tr> </table>	Last	First	Middle Initial			
Last	First	Middle Initial					
11. Summary of Claim							
<p>When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level IV – Myocardial Infarction, a QUSC must these documents:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A true and correct copy of all contemporaneous Medical Records of the cardiothoracic surgeon(s) and/or cardiologist(s) who diagnosed and treated the myocardial infarction; <input type="checkbox"/> A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the surgery that precipitated the Myocardial Infarction; <input type="checkbox"/> A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the treatment of the Myocardial Infarction, if different than above; and <input checked="" type="checkbox"/> A true and correct copy of the contemporaneous Medical Records establishing the claimant’s pre- and post-myocardial infarction change in Functional Classification (as defined by the New York Heart Association). 							

GREEN CLAIM FORM FOR EIF AWARD

N. MATRIX LEVEL V (Stroke)

This section relates only to **Matrix Level V (Stroke)** and should be completed only if a QUSC has suffered a stroke (i) during the ASR Revision Surgery or Covered Past Re-Revision Surgery, or (ii) during the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery (Section 8.4.14.1). An award under this section shall be based upon (a) the American Heart Association Stroke Outcome Classification and (b) the age of the patient on the date of the stroke, according to the PART B Award Schedule (Section 8.4.14.2). A transient ischemic attack, or TIA, is not a stroke for purposes of the Green Claim Form (Section 8.4.14.2.1). QUSCs who suffered a stroke in close temporal proximity to (in no event greater than 30 days), but following, the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery may be entitled to an award under this Section, based upon a process to be determined by the Team and the SOC at a later date, provided that the ASR Revision Surgery or Covered Re-Revision Surgery was a cause of the stroke (Section 8.4.14.1.1).

To submit a claim for **PAST Matrix Level V – Stroke**, the QUSC must have suffered a stroke before April 1, 2014. To submit a claim for **FUTURE Matrix Level V – Stroke**, the QUSC must suffer a stroke on or after April 1, 2014, and within two years of an ASR Revision Surgery. An award under this Future Matrix Level V shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level V, except that the Future Matrix Level V award will be subject to a reduction of up to 75%.

If a Product User has had more than one Stroke, make copies of this Section N for each Stroke and attach them to the signed Claim Form. A QUSC can receive only one Past Matrix Level V award, regardless of the number, type, or location of myocardial infarctions suffered, that is between \$85,000 and \$516,000 and based on the American Heart Association Stroke Classification and the QUSC’s age on the date of the stroke.

1. Matrix Type		<input type="checkbox"/> Past (Before April 1, 2014)	
		<input type="checkbox"/> Future (On or After April 1, 2014)	
2. Date of Stroke	____/____/____ (MM/DD/YYYY)	3. Date of Surgery that Precipitated Stroke	____/____/____ (MM/DD/YYYY)
4. Date of Discharge from Surgery	____/____/____ (MM/DD/YYYY)	5. American Heart Association Functional Stroke Outcome Classification	<input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV
6. Name of Hospital where Stroke was Diagnosed and Treated			
7. Name of Diagnosing/ Treating Neurosurgeon or Neurologist		Last	First
			Middle Initial
8. Summary of Claim			

GREEN CLAIM FORM FOR EIF AWARD

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level V – Stroke, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the neurosurgeon(s) and/or neurologist(s) who diagnosed and treated the stroke;
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the surgery that precipitated the stroke;
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the treatment of the stroke, if different than above; and
- A true and correct copy of the contemporaneous Medical Records establishing the claimant’s American Heart Association Functional Stroke Outcome Classification.

O. MATRIX LEVEL VI (Death)

This section relates only to **Matrix Level VI (Death)** and should be completed only if a Product User has died (i) during the ASR Revision Surgery or Covered Re-Revision Surgery, or (ii) during the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery (Section 8.4.14.5). A QUSC whose Product User died in close temporal proximity to, but following, the hospitalization for the ASR Revision Surgery or Covered Re-Revision Surgery may be entitled to an award under this Section, based upon a process to be determined by the Team and the SOC at a later date, provided the ASR Revision Surgery or Covered Re-Revision Surgery was a cause of the death (Section 8.4.14.5.1).

To submit a claim for **PAST Matrix Level VI – Death**, a Product User must have died before April 1, 2014. To submit a claim for **FUTURE Matrix Level VI – Death**, a Product User must die on or after April 1, 2014 and within two years of an ASR Revision Surgery or Covered Re-Revision Surgery. An award under this Future Matrix Level VI shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level VI, except that the Future Matrix Level VI award will be subject to a reduction of up to 75%.

1. Matrix Type	<input type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)		
2. Date of Product User’s Death	____/____/____ (MM/DD/YYYY)	3. Date of Surgery that Precipitated Product User’s Death	____/____/____ (MM/DD/YYYY)
4. Name of Hospital where Surgery that Precipitated Product User’s Death Occurred			
5. Name of Hospital where Product User’s Death Occurred			
6. Cause of Product User’s Death			
7. Marital Status at the Time of Product User’s Death	<input type="checkbox"/> Married <input type="checkbox"/> Divorced If Married, complete Items 8-13, where applicable. <input type="checkbox"/> Separated <input type="checkbox"/> Widowed If Separated, Divorced, or Widowed, complete Items 8-9, where applicable. <input type="checkbox"/> Single If Single, skip to Item 14.		
8. Date of Marriage	____/____/____ (MM/DD/YYYY)	9. Date of Separation or Divorce (if applicable)	____/____/____ (MM/DD/YYYY)

GREEN CLAIM FORM FOR EIF AWARD

10. Spouse Name	First	Middle	Last
11. Spouse Address	Street		
	City	State	Zip
12. Spouse Social Security Number	_ _ _ - _ _ - _ _ _ _ _		13. Spouse Date of Birth _ / _ / _ _ (MM/DD/YYYY)
14. Did the Product User have biological or adopted children who were living at the time of death?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, make a copy of Items 15-18 for each child and answer the necessary questions. If No, skip to Item 19.
15. Child Name	First	Middle	Last
16. Child Address	Street		
	City	State	Zip
17. Child Social Security Number	_ _ _ - _ _ - _ _ _ _ _		18. Child Date of Birth _ / _ / _ _ (MM/DD/YYYY)
Provide the necessary information for the Product User's Biological or Adopted Parents that were Alive at the Time of Product User's Death in Questions 19 thru 26. If neither of the Product User's Parents were alive at the time of the Product User's Death, skip to Question 27.			
19. Father Name	First	Middle	Last
20. Father Address	Street		
	City	State	Zip
21. Father Social Security Number	_ _ _ - _ _ - _ _ _ _ _		22. Father Date of Birth _ / _ / _ _ (MM/DD/YYYY)
23. Mother Name	First	Middle	Last
24. Mother Address	Street		
	City	State	Zip
25. Mother Social Security Number	_ _ _ - _ _ - _ _ _ _ _		26. Mother Date of Birth _ / _ / _ _ (MM/DD/YYYY)
27. Was the Product User employed at the time of death?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, complete Items 28-31. If No, skip to Item 32.

GREEN CLAIM FORM FOR EIF AWARD

28. Employed Since	____/____/____ (MM/DD/YYYY)	29. Job Title	
30. Employer Name			
31. Employer Address	Street		
	City	State	Zip
32. Summary of Claim			

When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level VI – Death, a QUSC must submit these documents:

- A true and correct copy of all contemporaneous Medical Records of the treating surgeon who performed the ASR Revision Surgery or Covered Past Re-Revision Surgery that you believe resulted in death;
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the ASR Revision Surgery or Covered Past Re-Revision Surgery that you believe resulted in death;
- A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records for the hospitalization (if different than above) leading up to the QUSC's death;
- Death Certificate and Autopsy Findings (if applicable);
- Documentation confirming a Minor Child's date of birth that may include a photocopy of his/her birth certificate, social security card, or driver's license; and
- Documentation (in the form of federal income tax-returns or W-2 statements) that evidences a QUSC's wages, salaries, or income from self-employment for the 3 years before his/her death.

P. MATRIX LEVEL VII (Discretionary)

This section relates only to **Matrix Level VII (Discretionary)** and should be completed only if a QUSC has suffered a truly extraordinary injury and/or loss as a result of an ASR Revision Surgery or covered Re-Revision Surgery or a condition directly related to the reason necessitating an ASR Revision Surgery or covered Re-Revision Surgery, that was either not anticipated or not provided for under Matrix Levels I-VI. (Section 8.4.15.1-2).

To submit a claim for **PAST Matrix Level VII – Discretionary**, a QUSC must have suffered a truly extraordinary injury and/or loss before April 1, 2014. To submit a claim for **FUTURE Matrix Level VII –Discretionary**, a QUSC must suffer a truly extraordinary injury and/or loss on or after April 1, 2014 and within two years of an ASR Revision Surgery or Covered Re-Revision Surgery. An award under this Future Matrix Level VII shall be calculated in the same manner and subject to the same limitations as an award under the Past Matrix Level VII, except that the Future Matrix Level VII award will be subject to a reduction of up to 75%.

If a Product User has had more than one Discretionary injury and/or loss, make copies of this Section P for each Discretionary Injury claimed and attach them to the signed Claim Form.

1. Matrix Type	<input checked="" type="checkbox"/> Past (Before April 1, 2014) <input type="checkbox"/> Future (On or After April 1, 2014)
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GREEN CLAIM FORM FOR EIF AWARD

2. Description of the Injury(ies) or Damage(s) that Resulted from an ASR Revision Surgery or Covered Re-Revision Surgery	Loss of earnings		
3. Date on which the Injury/Damage was Recognized	4 / 4 / 2012 (MM/DD/YYYY)		
4. Date of Surgery that Precipitated the Injury	4 / 4 / 2012 (MM/DD/YYYY)		
5. Name of Diagnosing/ Treating Physician	Last JONES	First BOB	Middle Initial
Answer Questions 6 and 7 if the Product User seeks lost earnings compensation. If the Product User does not seek lost earnings compensation, skip to Question 8.			
6. Total Amount of Unreimbursed Lost Earnings Claimed	\$ 5,600.00		
7. Identify all payments received in place of lost earnings, such as disability benefits, social security, Broadspire, or state that the Product User did not receive any reimbursements.	The Product User did not receive any reimbursements.		
8. Summary of Claim	Ms. Doe was unable to work for four months as a result of the foot drop that she experienced after her Re-Revision Surgery.		
<p>When submitting a Green Claim Form for EIF Benefits that includes a claim for Matrix Level VII – Discretionary, a QUSC must submit these documents:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A true and correct copy of all contemporaneous Medical Records of the treating physician(s) who performed the ASR Revision Surgery or covered Re-Revision Surgery (that you believe resulted in injury/damage); <input type="checkbox"/> A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to the ASR Revision Surgery or covered Re-Revision Surgery (that you believe resulted in injury/damage); <input type="checkbox"/> A true and correct copy of the contemporaneous Medical Records, including Admission History and Physical Examination Records, Discharge Summaries and Operative Records pertaining to treatment for the injury/damage claimed; <input type="checkbox"/> A true and correct copy of all contemporaneous Medical Records of the treating physician(s) who diagnosed and/or treated the injury/damage claimed; <input type="checkbox"/> To the extent applicable, a true and correct copy of the contemporaneous Medical Records of the treating physician(s) who diagnosed and/or treated the medical contra-indication that delayed a QUSC's ASR Revision Surgery – leading to a reduction in the QUSC's Part A Base award; and <input type="checkbox"/> To the extent applicable, documentation that evidences a QUSC's unreimbursed (out of pocket) loss of earnings, including, but not limited to, federal income tax returns or W-2 statements for the two years preceding the ASR Index Surgery as well as for the years in which an earnings loss is being claimed and any documentation relating to disability coverage and determinations. 			

GREEN CLAIM FORM FOR EIF AWARD

Q. CERTIFICATION BY CLAIMANT

I declare under penalty of perjury under 28 U.S.C. §1746 that all of the information provided in and with this Claim Form is true and correct to the best of my knowledge, information and belief.

I further certify that by participating in this U.S. Program, I agree to abide by the terms of the Agreement, and further understand that by enrolling in the Settlement Program, I agree to be bound by the terms of MDL Case Management Order 13, as amended, which permits a holdback of 5% fees and 1% costs to be deducted from any final award/gross recovery to me from the U.S. Program which shall be used, in part, for the funding of the administration of the U.S. Program. I further agree to comply with any Orders entered by the United States District Court for the Northern District of Ohio (MDL Docket No. 1:10-md-2197) in the furtherance of Case Management Order 13, and consent to the jurisdiction of that MDL Court for that purpose. I further grant and convey to the Settlement Oversight Committee for MDL 2197 a lien upon and/or security interest for such holdback amounts in any recovery by me from the U.S. Program. If I qualify for a settlement award payment pursuant to the terms of the Agreement, I authorize such settlement payment to be made to my Counsel identified as my Primary Law Firm in trust for me in accordance with the Agreement.

Claimant's Signature			Date	_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	
R. COUNSEL SIGNATURE				
Counsel's Signature			Date	_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	