Law Firm Code:
Attorney Name:
Contact Name:

FULLER-AUSTIN SETTLEMENT TRUST

FULLER-AUSTIN ASBESTOS SETTLEMENT TRUST
("FAST") Submit completed claims to:

Fuller-Austin Asbestos Settlement Trust
c/o Verus Claims Services, LLC
3967 Princeton Pike, Princeton, NJ 08540
trustsupport@verusllc.com

FULLER-AUSTIN CLAIM FORM

Part 1: INJURED PARTY INFORMATION

1.1 Injured Party:_____ SSN: _____
(Please print FULL NAME)

Mailing Address:_____
(Street/PO Box)

_____ _____ _____
City State Zip

Date of Birth: _____ / _____ / _____ Daytime Phone: (_____)_____

1.2 Is Injured Party living? Yes _____ No_____ If Deceased: Date of Death: _____ / _____ / _____

1.3 If Injured Party or the Injured Party's estate or heirs has a representative, (the "Claimant Representative"), other than the licensed attorney submitting this claim form, provide the following for the Claimant Representative:

1.3.1 Name:_____ Daytime Phone: (_____)_____

Mailing Address:_____
(Street/PO Box)

_____ _____ _____
City State Zip

1.3.2 Capacity: Executor: _____ Administrator: _____ Guardian: _____

1.3.3 Relationship: Spouse: _____ Child: _____

Part 2: ASBESTOS LITIGATION

2.1 Has a lawsuit ever been filed on behalf of the Injured Party? Yes _____ No _____

2.2 Was Fuller-Austin Insulation Company or DynCorp named as a defendant? Yes _____ No _____

2.3 Court: _____ State: _____ Date Filed: _____ / _____ / _____

2.4 What is the current status of this suit? Pending _____ Judgment _____ Dismissed _____ Settled _____

For your claim to be evaluated by FAST, (i) Fuller-Austin and/or DynCorp must have been dismissed or non-suited in all lawsuits in which the Injured Party for whom this claim is filed is the source of the alleged damage or loss suffered by the Plaintiff in a related lawsuit (such as loss of consortium filed by a spouse) and (ii) no action shall be taken subsequently against Fuller-Austin, DynCorp or the Fuller-Austin Asbestos Settlement Trust other than as provided by the Plan of Reorganization and the Order Confirming the Plan of Reorganization.

2.5 Have Fuller-Austin Insulation Company and/or DynCorp been dismissed or non-suited in all lawsuits in which the Injured Party for whom this claim is filed is the source of the alleged damage or loss suffered by the Plaintiff in a related lawsuit (such as loss of consortium filed by a spouse)? Yes _____ No _____

Part 3: MEDICAL HISTORY

Provide date of diagnosis for each asbestos-related disease claimed. The required medical documentation for each claimed asbestos-related disease must be attached. See Instructions for Filing a Claim with the Fuller-Austin Settlement Trust for required medical information for each asbestos-related disease.

3.1 **DISEASE CLAIMED** **Date of Diagnosis**

Mesothelioma _____ / _____ / _____

Lung Cancer _____ / _____ / _____

Other Cancer:
If Other Cancer is claimed, the date of an underlying diagnosis for Asbestosis or Pleural Disease must also be provided below and medical documentation must be submitted to support the existence of both the Other Cancer and the underlying disease.

Pharyngeal _____ / _____ / _____

Laryngeal _____ / _____ / _____

Esophageal _____ / _____ / _____

Epiglottal _____ / _____ / _____

Stomach _____ / _____ / _____

Colo-Rectal _____ / _____ / _____

Asbestosis _____ / _____ / _____

Pleural Disease _____ / _____ / _____

3.2 **SMOKING/TOBACCO HISTORY**

Does (has) the Injured Party (choose one):

Currently Smokes_____ Formerly Smoked_____ Never Smoked_____

Part 4: OCCUPATIONAL EXPOSURE

Complete this part only if the Injured Party's asbestos-related disease is a result of direct exposure to asbestos products sold, installed or removed by Fuller-Austin Insulation Company ("FA ACM"), as opposed to exposure through some other person. If the Injured Party's exposure is through another person, complete Part 5: EXPOSURE THROUGH AN OCCUPATIONALLY EXPOSED PERSON.

Exposure to FA ACM:

4.1 Was the Injured Party's only asbestos exposure as an employee of Fuller-Austin Insulation Company? Yes _____ No _____

4.2 Was the Injured Party exposed to FA ACM? Yes _____ No _____

If yes to either of the above, and the Injured Party's employment involved exposure to FA ACM, please refer to that employment when completing the remainder of Part 4 of the claim form.

FA ACM Job Site Information:

Complete the following information for each site where the Injured Party was exposed to FA ACM. (For additional sites, photocopy this page.)

4.3 Employer:_____

4.4 Plant or Site:_____

_____ _____
(City) (State)

4.5 Date Exposure Began: _____/_____/_____ Date Exposure Ended: _____/_____/_____

4.6 Occupation:_____

If the Injured Party's exposure to FA ACM is not typically associated with the occupation and industry claimed, describe how the Injured Party was exposed to FA ACM while working in the occupation and industry claimed.

_____

_____

4.7 Industry:_____ If Code 21 (Other), specify:_____

Industry Codes

1. Aerospace/aviation
2. Asbestos abatement
3. Automobile mechanical/friction
4. Chemical
5. Construction trades
6. Iron/steel
7. Longshore
8. Maritime
9. Military
10. Non-asbestos products manufacturing
11. Petrochemical
12. Insulation
13. Railroad
14. Shipyard-construction/repair
15. Textile
16. Tire/rubber
17. Utilities
18. Fuller-Austin Insulation products distribution
19. Non-Fuller-Austin Asbestos Manufacturing/ mining/distribution products
20. Building Occupant/Bystander
21. Other:_____

4.8 How closely did the Injured Party work with FA ACM at this exposure site only?

☐	☐	☐	☐
Worked or resided in a building where FA ACM were previously installed, but not visible	Worked in an area of a building where FA ACM were previously installed and visible	Worked in a specific area where FA ACM were being installed or removed	Handled FA ACM

INJURED PARTY:_____ SSN:_____

Part 5: EXPOSURE THROUGH AN OCCUPATIONALLY EXPOSED PERSON

Complete this part only if the Injured Party's asbestos-related disease is a result of exposure to FA ACM through an Occupationally Exposed Person ("OEP").

Provide the following for each OEP claimed. (For additional OEPs, photocopy this page.)

Injured Party's FA ACM Exposure Through OEP:

5.1.1 Is the Injured Party alleging an asbestos-related disease resulting solely from exposure to an OEP, such as a family member (spouse, father, sister, etc.)? Yes _____ No _____

5.1.2 The Injured Party's first such exposure to FA ACM through the OEP was on _____/_____/_____

5.1.3 The Injured Party's last such exposure to FA ACM through the OEP was on _____/_____/_____

5.1.4 Describe the Injured Party's exposure to FA ACM through the OEP that is alleged to be the cause of the Injured Party's asbestos-related disease:

_____

_____

OEP's FA ACM Exposure Information:

5.2 Name of OEP: _____

5.3 Social Security Number of OEP: _____

5.4 Employer: _____

5.5 Plant or Site: _____

_____ _____
(City) (State)

5.6 Date Exposure Began: _____/_____/_____ Date Exposure Ended: _____/_____/_____

5.7 Occupation: _____

If the OEP's exposure to FA ACM is not typically associated with the occupation and industry claimed, describe how the OEP was exposed to FA ACM while working in the occupation and industry claimed.

_____

_____

5.8 Industry: _____ If Code 21 (Other), Specify: _____

Industry Codes

1. Aerospace/aviation
2. Asbestos abatement
3. Automobile mechanical/friction
4. Chemical
5. Construction trades
6. Iron/steel
7. Longshore
8. Maritime
9. Military
10. Non-asbestos products manufacturing
11. Petrochemical
12. Insulation
13. Railroad
14. Shipyard-construction/repair
15. Textile
16. Tire/rubber
17. Utilities
18. Fuller-Austin Insulation products distribution
19. Non-Fuller-Austin Asbestos Manufacturing/ mining/distribution products
20. Building Occupant/Bystander
21. Other: _____

5.9 How closely did the OEP work with FA ACM at this exposure site only?

☐	☐	☐	☐
Worked or resided in a building where FA ACM were previously installed, but not visible	Worked in an area of a building where FA ACM were previously installed and visible	Worked in a specific area where FA ACM were being installed or removed	Handled FA ACM

INJURED PARTY: _____ SSN: _____

Part 6: CLAIM FORM CERTIFICATION

6.1 The following documents are required to be submitted with this claim form: (Place a checkmark in the box next to the document once it has been enclosed with this claim form)

- ☐ Death Certificate (if applicable)
- ☐ Claimant Representative documents (if applicable)
- ☐ Medical documentation supporting the Injured Party's asbestos-related disease(s)
- ☐ Exposure documentation supporting the Injured Party's exposure to FA ACM

6.2 This claim is certified by: (check one)

☐ The Injured Party ☐ The Claimant Representative

I, _____, certify, under penalty of perjury, that I am authorized to file this Claim Form and I have reviewed the information submitted on this claim form and all documents submitted in support of this claim and that, to the best of my knowledge, the information submitted is true, accurate and complete.

_____
Signature of Injured Party or Claimant Representative

_____
Printed name

OR

☐ The Attorney authorized to file this Claim Form

The undersigned certifies, under penalty of perjury, as follows: I am authorized to file this Claim Form; I, or other trained personnel within my firm, have reviewed the information submitted on this Claim Form and all documents submitted in support of this claim; and to the best of my knowledge, based on policies and procedures adopted and implemented by my firm concerning claims processing, the information submitted is true, accurate and complete, and/or the information is included within the claimant's file and is derived from information provided by the claimant, one or more of the claimant's co-workers or the claimant's medical experts.

_____
Signature of Attorney

_____
Printed name

Part 7: ATTORNEY CERTIFICATION AND WARRANTY OF CLAIMANT REPRESENTATIVE'S AUTHORITY

This section must be executed by the Attorney only if (i) the Injured Party has a Claimant Representative and (ii) the Affidavit & Indemnity establishing the Claimant Representative's capacity is not submitted with this claim form.[6]

The Attorney certifies and warrants that this claim is filed on behalf of the Injured Party by the Claimant Representative and that the Claimant Representative is authorized by law to file this claim on behalf of the Injured Party.

_____
Signature of Attorney

_____
Printed name