IN RE: PROPULSID® PRODUCTS LIABILITY LITIGATION

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

MDL NO. 1355

RESOLUTION PROGRAM

CLAIM FORM FOR ALLEGED WRONGFUL DEATH (TIER I)

TO BE FILLED OUT BY PLAINTIFF OR CLAIMANT (WITH OR WITHOUT ASSISTANCE OF COUNSEL)

I.
AGREEMENT AND INSTRUCTIONS

A. This form is to be used for submitting alleged wrongful death claims by or on behalf of any Propulsid® Plaintiff in a lawsuit filed in or removed to Federal Court before February 1, 2004, which was then pending in the MDL 1355 Court or was in the course of being transferred or hereafter is transferred to the MDL 1355 Court by the MDL Panel (hereafter, "Plaintiff"), or by or on behalf of any Propulsid® claimant on a signed Tolling Agreement (including Plaintiffs in the Master Complaint of Louisiana Propulsid® Claimants, known as the Achord action, filed in the USDC, E. Dist. of LA) (hereafter, "Claimant") who has timely enrolled in the Propulsid® MDL 1355 Resolution Program (hereafter, the "Program") as described in the MDL 1355 Term Sheet dated April 30, 2004, which is incorporated herein in its entirety.

B. To properly submit this Claim Form, read the Claim Form in its entirety and answer all of the inquiries in it on the Claim Form itself [and add additional sheets if necessary] and then sign and date the Claim Form [and all additional sheets] and complete a Certificate of Service of the Claim Form in a format similar to that contained in the template Certificate of Service of Claim Form located at Attachment B; and:

C. It is recognized that there may be conditions which prevent you from providing all the information sought in this claim form and in providing all the required medical records. However, your vigorous diligence in providing that information and in providing those records is required. The Medical Review Panel has the discretion to approve or deny your claim based on the information that you submit.

D. (a) Serve the **originals** of:

(i) the completed, signed and dated Claim Form; and

(ii) the completed, signed and dated Attachments B, C and D, being sure that in Attachment B (the Certificate of Service of Claim Form for Wrongful Death), you check off the manner of service.

(b) the **originals** of these executed documents should be served on:

Special Master's Office
In re: Propulsid MDL 1355 Resolution Program
400 Poydras Street, Suite 2820
New Orleans, LA 70130
Telephone: (504) 586-7995

E. You must submit this Claim Form and serve it in the manner described below within 120 days of service of notice by the Plaintiffs' Steering Committee ("PSC") that the Program's minimum enrollment levels have been reached, or within 120 days of service of your enrollment form, whichever is later.

F. Within 60 days after service of your Claim Form, you must submit all required medical records for review, unless pursuant to Section 7 of the Term Sheet, upon application to the special master, you have demonstrated a good faith effort to secure the medical records, then the period for securing records shall be extended for an additional 60 days. (see Attachment A to this Claim Form for a description of the 'medical records requirements' contained in Section 2 of Exhibit A to the Term Sheet.)

G. If you fail to submit the medical records required to process your claim within 60 days after you serve your Claim Form, then subject to the exception in Section 7 of the Term Sheet allowing for an additional 60 days to secure records upon a showing of good faith effort to secure the records (made by application to the special master), your claim shall be dismissed in its entirety with prejudice. No further action is to be taken on it and no litigation may be commenced or maintained to attempt to pursue that or any other Propulsid®-related claim.

H. Within 60 days of submission of your medical records, the parties may simultaneously submit to the medical panel confidential memoranda explaining the parties' contentions as to your decedent's qualification or non-qualification under the

program and the category under which the claim is submitted. Pursuant to Section 13 of the Term Sheet, said memorandum is not to exceed five pages; exhibits to the memorandum may be abstracts or full documents not to exceed thirty pages. No expert reports or affidavits shall be submitted. (see Section 13 of the Term Sheet for details.)

I. You also acknowledge that before you will be paid any award you may be granted under this Program, you shall be required to provide Lead Counsel to Defendants with the information with which to draft any further documentation required by the Term Sheet. Once those documents are prepared, you must execute and return them to Lead Counsel for Defendants. The prerequisites to your receiving payment of any award to which you are deemed entitled under this Program include but are not limited to the following:

1. With respect to alleged wrongful death claims arising in states which limit the right to file and/or settle a wrongful death claim to those persons appointed by a local state court to maintain and/or settle such a claim, the Plaintiff/Claimant submitting an alleged wrongful death claim under this Program must represent and warrant that they have been appointed by court order as the proper representative, and said Plaintiff/Claimant must present proof of such appointment (e.g., a copy of the operative court order or Letters of Administration) to Lead Counsel for Defendants; and

2. With respect to claims that fall into the description contained in the immediately preceding paragraph, to the extent the requisite court appointment has not been obtained, Plaintiff or Claimant hereby agrees that no award to which they might be entitled under this Program shall be paid until proof is provided to Lead Counsel for Defendants that the Plaintiff or Claimant has since obtained the requisite court appointment (and that all necessary follow-up steps, such as substitution of the proper party into any filed lawsuits, have occurred); and

3. With respect to alleged wrongful death claims arising in states that do not require court appointment of a designated representative to file and/or settle a wrongful death claim, but instead limit the right to file and/or settle a wrongful death claim to a particular heir or heir(s), albeit without court appointment, the Plaintiff/Claimant enrolling in this Program must represent and warrant to the satisfaction of Lead Counsel for Defendants that under applicable state law, he or she is one of the statutory heirs who has the right to file and/or settle a wrongful death claim arising out of decedent's death; and

4. With respect to claims that fall into the description contained in the immediately preceding paragraph, if the Plaintiff or Claimant who enrolled in this Program is not one of the statutory heirs with the right under state law to file and/or settle a wrongful death claim without court appointment, no award reached under this Program shall be paid until proof is presented to Lead Counsel for Defendants that the proper heir has been substituted as a party to any existing lawsuits and has been enrolled in this Program; and

5. In addition to the above requirements, before an award will be paid on any wrongful death claim, you must identify by full name, relationship to decedent, date of birth and Social Security number all statutory heirs (persons who, under applicable state law, had or have the right to file a wrongful death claim as a result of decedent's death or are those entitled to share in any settlement proceeds). Moreover, all statutory heirs must comply with the provisions of the Term Sheet before any award will be paid.

J. You also acknowledge that pursuant to Section 20 of the Term Sheet, upon submitting the requisite Claim Form, you must state whether or not you have reached a settlement with an entity other than the Janssen and Johnson & Johnson defendants. You also agree that if it is determined that you are eligible for an award payment, you must inform the Special Master exclusively of the amount of any such settlement.

K. By having enrolled in this Program, you acknowledged that the decisions of the Medical Panel and Special Master may be ones with which you disagree, but further acknowledge that this eventuality is part of the Program, and you accepted that eventuality by having authorized your attorney to enroll you in the Program. You further specifically agree that the decisions of the Medical Panel and Special Master are final and not appealable.

L. It is acknowledged that, having enrolled in this Program, you thereby surrendered your rights to litigate your case and any other claims and potential claims relating in any way to Propulsid®, including but not limited to all claims, liabilities, demands, actions, suits and causes of actions for damages (including but not limited to current and future causes of action for wrongful death, and current and future causes of action for personal injury and loss of consortium), restitution, disgorgement, unjust enrichment, civil penalties, statutory penalties, injunctive and/or declaratory relief, whether class, individual, representative or otherwise in nature, including costs, expenses, penalties, and attorneys' fees, known or unknown, suspected or unsuspected, in law or equity, that accrued prior to the date of enrolling in the Program that you ever had, now have or hereafter can, shall or may have, which has been asserted or could have been asserted in the MDL or in any other action, and you acknowledge that having enrolled in the Program, you unconditionally, fully and forever released whatever rights you and your decedent's heirs and representatives may have had, or may ever have, against defendants Johnson & Johnson, Janssen Pharmaceutica Inc. and Janssen Pharmaceutica, N.V., all health care professionals, health care providers, health care facilities, pharmacies and other distributors of Propulsid®, and their parents and subsidiaries, affiliates, agents, attorneys, servants, employees, officers and directors and those who may have acted in concert with them, together with their respective insurers relating to your decedent's alleged ingestion of Propulsid®. You also acknowledge that when you enrolled in the Program, you were authorized to release the aforementioned claims on behalf of yourself and decedent's heirs, beneficiaries and representatives and that you waived California Civil Code Section 1542, if applicable, which provides that, "a general

release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor." You also acknowledge that if the Medical Panel determines that you are entitled to an award under this Program, you must comply with all of the provisions of the Term Sheet prior to payment of such award, including but not limited to preparing any documentation called for under the Term Sheet for finalizing payment of the award.

Attorneys for Claimants and/or Plaintiffs shall provide a completed W-9 Form, a copy of which is attached hereto as Attachment D, which form shall provide, among other things, the appropriate tax identification number for that attorney.

M. The signatories to the Claim Form, the law firms with which they are affiliated and the Plaintiffs and Claimants identified on Attachment A specifically agree to maintain the confidentiality of any awards of compensation that might result from the Program.

N. You agree to execute and serve with this Claim Form the original Authorization to Release Medical Records attached hereto as Attachment C.

II.
CLAIM FORM FOR WRONGFUL DEATH (TIER I) CLAIM

A. ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, AS NECESSARY, ATTACH ADDITIONAL SHEETS:

1. Decedent Information:

a. Current name and other names (e.g., maiden names, married names) used by now-deceased alleged Propulsid® user for the ten years prior to death (last name first, followed by first name and middle initial):

_____

b. Decedent's Last Known Residence Address:

_____

_____

_____

c. Decedent's Date of Birth: _____

d. Decedent's Date of Death: _____

e. Decedent's Social Security Number: _____

2. Plaintiff(s)'/Claimant(s)' Information for all Plaintiffs/Claimants Submitting this Claim re: the above-listed Decedent [attach separate sheet(s) as necessary to answer all of the following questions re: each Plaintiff/Claimant]:

a. Current name and other names used by each Plaintiff/Claimant at the time of and subsequent to Plaintiff's filing of Propulsid® lawsuit re Plaintiff's decedent or at the time of or subsequent to Claimant entering into a Tolling Agreement or joining the Achord action with respect to Claimant's decedent (last name first, followed by first name and middle initial):

_____

b. Plaintiff's/Claimant's Current Residence Address:

_____

_____

_____

c. Date of Birth: _____

d. Social Security Number: _____

e. Relationship to Decedent: _____

f. Details re: relationship to Decedent (whether Plaintiff/Claimant is the court-appointed representative of Decedent's estate, etc.): _____. If a court-appointed representative, please attach copies of the Letters of Administration or other court orders making such appointment.

3. Decedent's Alleged Propulsid® Use:

a. Date(s) ingested: _____

b. Dosage(s) ingested (amount (e.g., 20 mg.) and number daily):
_____/_____

c. Ordering Physician(s) Name(s), Addresses and Phone Numbers:

_____

d. Pharmacies where all Propulsid® Prescriptions were ever filled (names, addresses and phone numbers of all such pharmacies):

_____

_____

_____

4. Other Medications Used by Decedent:

a. For each prescription medication ingested by decedent during the three years prior to the adverse event leading to decedent's death (or during decedent's entire life if decedent was under age 12 at time of death), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

b. For each over-the-counter medication ("OTC") medication ingested by decedent during the three months prior to the adverse event leading to decedent's death (or during decedent's entire life if decedent was under age 12 at time of death), provide:

Name of drug and where purchased	Date(s) ingested	Ordering MD, if one

5. Alleged Adverse Event/Injury:

a. Date of Adverse Event Allegedly Leading to Decedent's Death:

_____

b. Description of Nature of Adverse Event Allegedly Leading to Decedent's Death:

_____

c. Names, Addresses, Telephone Numbers of Physician(s), Physician's Assistants and Nurse Practitioners who treated Decedent for the alleged injuries or adverse event he or she suffered that are being attributed to Decedent's alleged ingestion of Propulsid® and the dates of such treatment from the date of the alleged injury to date of death. (Include names, addresses and phone numbers of any pertinent treatment facilities, including but not limited to hospitals, ambulance or paramedic companies, fire department rescue crews, police and sheriff investigators, medical examiners and the issuers of autopsy reports and death certificates.)

_____

_____

_____

6. Medical Treatment History:

a. For all medical treatment, of any kind, received by Decedent in the one year prior to death from any type of medical practitioner (doctors, physician's assistants, nurse practitioners, therapists, hospitals, clinics, pharmacies, ambulance services, paramedic companies and home health services) provide for each:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

b. For each of Decedent's emergency room visits and hospitalizations during the three years preceding Decedent's Adverse Event/Death (or for a decedent who was less than age 12 at time of death, for their entire life), provide the following:

(i) facility name;

(ii) facility address;

(iii) condition leading to hospitalization;

(iv) dates of admission; and

(v) duration of hospitalization.

c. For all of the following cardiac studies ***excluding*** **ECGs** (see 6.e. below re ECGs), performed during the three years before Decedent's alleged adverse event (or if decedent was under age 12 at time of death, during decedent's entire life), ***including*** holter monitoring, stress tests, heart scans, echo-cardiograms, cardiac angiography/catheterization, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

d. For the three years prior to Decedent's alleged adverse event (or if Decedent was under 12 at the time of the adverse event, during Decedent's entire life) for all treatment received by Decedent from Decedent's primary care physician(s), cardiologist(s), gastroenterologist(s) and/or pediatrician(s), provide:

(i) name;

(ii) address and telephone number;

(iii) medical specialty; and

(iv) date(s) seen.

e. For the ten years prior to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life) for each ECG, provide:

Name of test	Date performed	Location of test and Name of Provider Who Ordered Test

f. For the ten years prior to the adverse event allegedly related to Decedent's Propulsid® use and allegedly leading to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life), provide the following for all hospital records where cardiac concerns were implicated. Cardiac concerns include but are not limited to chest pain or angina, syncope (fainting or near fainting), heart attack, congestive heart failure, hypertension, cardiomyopathy, valvular disease, infections of the heart or heart valve and myocarditis.

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

g. For the ten years prior to the adverse event allegedly related to Decedent's Propulsid® use and allegedly leading to Decedent's death (or if Decedent was less than 12 years old at time of death, for Decedent's entire life), provide the following for all hospital records where GI concerns were implicated:

(i) name;

(ii) address;

(iii) phone number; and

(iv) dates of treatment.

h. For each insurance or other company that provided medical bill coverage for Decedent's health care for treatment of Decedent's alleged Propulsid-related adverse event from the date of said adverse event through the date of Decedent's death.

(i) company name of insurer;

(ii) address and telephone number; and

(iii) dates of coverage.

i. If any of decedent's medical expenses relating to his/her alleged ingestion of Propulsid® were covered by Medicare, Medicaid or military benefits, i.e., V.A. or Tri-Star, so state, and describe any medical liens of which you are aware:

_____

7. **Economic Losses:**

List all economic losses you are claiming, including but not limited to lost wages, and in the event you are claiming economic loss in the form of lost wages, provide the name and address of decedent's employer, decedent's title at his or her place of employment and decedent's dates of employment claimed to have been lost due to Propulsid® use:

_____

_____

_____

8. **Propulsid®-Related Settlements With Other Third Parties:**

a. State whether you have reached a settlement with any other party besides one of the Janssen or Johnson & Johnson defendants, e.g., including but not limited to with a doctor, hospital, pharmacy, or insurer:

_____

b. If you answered "yes" to question II.8.a. above, identify the name of the person and/or entity with whom the settlement was reached:

9. Pendency of Propulsid® Lawsuits and/or Claims:

a. State whether you are involved in any pending Propulsid®-related lawsuit or claim other than the one for which you are submitting this Wrongful Death Claim Form:

_____

b. If you answered "yes" to question IV.9.a. above, describe the name of, venue of, docket number (if a filed lawsuit) and parties to the lawsuit(s) and/or claim(s):

_____

_____

_____

B. COMPLETE, SIGN AND DATE CERTIFICATE OF SERVICE OF CLAIM FORM FOR WRONGFUL DEATH (TIER I) CLAIM IN THE FORM CONTAINED IN THE TEMPLATE CERTIFICATE OF SERVICE IN ATTACHMENT B.

C. SIGN AND DATE BELOW.

Dated: _____ [Plaintiff's/Claimant's Signature]
[Representative of Decedent]
Printed Name of Plaintiff/Claimant Rep
Printed Residence Address

Dated: _____ [Signature of Plaintiff's/Claimant's Attorney
Printed Individual Attorney Name
Law Firm Name, Address, Telephone/Fax

PROPULSID® MDL 1355 RESOLUTION PROGRAM

ATTACHMENT A TO ALL CLAIM FORMS

(Pursuant to Section 2. of Exhibit A to the Term Sheet)

2. MEDICAL RECORD REQUIREMENTS

A. **For a person who was age 12 or older at the time of the event.** The person's relevant medical records as defined in subpart D below, immediately preceding the date of the event must be provided to the Medical Panel.

B. **For a person who was under 12 at the time of the event.** The person's relevant medical records from birth through the date of the event must be provided to the Medical Panel

C. **For all people.** The person's relevant medical records from the time of the event until death, or until 60 days before the time the case is submitted under The Program, whichever is applicable. These records are of particular importance in the evaluation process.

D. **Relevant records.** For the purpose of this Program,. The following are a person's relevant medical records. Time periods are deemed appropriately modified where the person was less than twelve years of age at the time of the event. The PSC and J&J may agree to order supplemental records at the expense of the administrative expense fund.

(1) **The one-year period before the event.** Full records for any kind of medical care in the one year preceding the event (doctor, hospital, pharmacy, ambulance, therapy, etc.).

(2) **The three year period before the event.**

(a) Full hospital records for hospitalizations.

(b) All electrocardiogram, holter monitor, and other cardiac monitoring or testing records for the three years before the event.

(c) Physician records from the person's primary care physician or physicians (if any), cardiologist or cardiologists (if any), gastroenterologists and/or pediatrician or pediatricians (if any).

(d) Prescription records for all prescribed medications.

(3) **The ten-year period before the event.**

(a) Full hospital records where cardiac concerns are implicated.

(b) Full hospital records where GI concerns are implicated.

(c) Full EKG's.

ATTACHMENT B TO CLAIM FORM FOR WRONGFUL DEATH CLAIM

CERTIFICATE OF SERVICE OF CLAIM FORM FOR WRONGFUL DEATH (TIER I) CLAIM

I, [**INSERT** name of signatory], declare that:

I am at least 18 years of age, and not a party to the above-entitled action. My business address is _____, Telephone: _____.

On_____, I caused to be served the following document(s):

CLAIM FORM(S) FOR WRONGFUL DEATH (TIER I) CLAIM(S) OF [INSERT NAME OF PLAINTIFF/CLAIMANT OR IF SERVING MORE THAN ONE WRONGFUL DEATH CLAIM FORM WITH THIS CERTIFICATE, INSERT NAMES OF ALL PLAINTIFFS/CLAIMANTS WHOSE FORMS ARE BEING SERVED WITH THIS CERTIFICATE

by enclosing a the **originals** of said document(s) in (an) envelope(s), addressed as follows:

☐ BY MAIL: I am readily familiar with the business' practice for collection and processing of correspondence for mailing with the United States Postal Service. I know that the correspondence is deposed with the United States Postal Service on the same day this declaration was executed in the ordinary course of business. I know that the envelope was sealed, and with postage thereon fully prepaid, placed for collection and mailing on this date, following ordinary business practices, in the United States mail at **[City and State.]**.

☐ BY PERSONAL SERVICE: I caused such envelopes to be delivered by a messenger service by hand to the address(es) listed below:

☐ BY OVERNIGHT DELIVERY: I enclose the **originals** of said document(s) in a Federal Express envelope, addressed as follows:

Special Master's Office
In re: Propulsid MDL 1355 Resolution Program
400 Poydras Street, Suite 2820
New Orleans, LA 70130
Telephone: (504) 586-7995

///

///

I declare under penalty of perjury under the laws of the State of [insert State of service] that the above is true and correct.

Executed on [Date] at [City and State].

_____
[Name]

DRINKER BIDDLE & REATH LLP
50 Fremont Street, 20th Floor
San Francisco, CA 94105

PROPULSID® MDL 1355 RESOLUTION PROGRAM
ATTACHMENT C TO ALL CLAIM FORMS

RECORDTRAK
The Track Record of Success

HIPAA COMPLIANT AUTHORIZATION FORM PURSUANT TO 45 CFR 164.508

Name or specific identification of the person(s), or class of persons, authorized to make the requested disclosure (Provider List):

TO: _____

_____

_____

Patient Name: _____

AKA's: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

I authorize the disclosure of all protected medical information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information spanning the time period of _____ to _____ including the following:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, itemized bills, and insurance records.

I authorize you to release the protected health information to:
RecordTrak, 651 Allendale Road, PO Box 61591 King of Prussia, Pennsylvania 19406.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.
I acknowledge the right to revoke this authorization by writing to the ROA Agent at Recordtrak at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.
I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.
Any facsimile, copy or photocopy of the authorization shall authorize you to release the records herein.

This authorization expires one year from the date below.

Signature: _____ Date: _____
Relationship to the person who is the subject of the records:

Self: _____ Other: _____
Describe authority

PAGE 15 OF 16 -- PLEASE READ ALL PAGES

PROPULSID® MDL 1355 RESOLUTION PROGRAM
ATTACHMENT D TO ALL CLAIM FORMS

Form W-9 **Taxpayer Identification Number Request** Rev. March 2003

To: _____ Account Number: _____

Please complete the following information. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 30% federal income tax backup withholding (29% after December 31, 2003). Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 30% of its payment to you (29% after December 31, 2003). Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Use this form only if you are a U.S. person (including U.S. resident alien). If you are a foreign person, use the appropriate Form W-8.

Instructions: 1. *Complete Part 1 by completing the one row of boxes that corresponds to your tax status.*
2. *Complete Part 2 if you are exempt from Form 1099 reporting.*
3. *Complete Part 3 to sign and date the form.*
4. *Return this completed form to us in the enclosed envelope.*

Part 1 – Tax Status: *(complete only one row of boxes)*

Individuals: *(Fill out this row.)*	Individual Name: (First name, middle initial, last name) _____ _____ _____	Individual's Social Security Number ___ - ___ - ____

A sole proprietorship may have a "doing business as" trade name, but the legal name is the name of the business owner.

Sole Proprietor: *(Fill out this row.)*	Business Owner's Name: (REQUIRED) _____ (First Name) _____ (Middle Initial) _____ (Last Name)	Business Owner's Social Security Number ___ - ___ - ____ or Employer ID Number ___ - ____	Business or Trade Name (OPTIONAL) _____ _____

Partnership: *(Fill out this row.)*	Name of Partnership: _____ _____	Partnership's Employer Identification Number ___ - ____	Partnership's Name on IRS records *(see IRS mailing label)* _____ _____

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity: *(Fill out this row.)*	Name of Corporation or Entity: _____ _____	Employer Identification Number ___ - ____

Part 2 – Exemption: If exempt from Form 1099 reporting, check your qualifying exemption reason below:

- ☐ Corporation Note that there is no corporate exemption for medical and healthcare payments or payments for legal services.
- ☐ Tax Exempt Entity under 501(a) (includes 501 (c)*(3)*), or IRA
- ☐ The United States or any of its agencies or instrumentalities
- ☐ A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or agencies
- ☐ A foreign government or any of its political subdivisions or an international organization in which the United States participates under a treaty or Act of Congress

Part 3 – Certification:

I certify under penalty of perjury that the Tax Identification Number I have provided is correct:

Person completing this form: _____
Signature: _____ Date: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ ZIP: _____

Please return this form in the enclosed envelope. Thank you for your cooperation.