Owens Corning/Fibreboard
ASBESTOS PERSONAL INJURY TRUST
PROOF OF CLAIM FORM

Submit completed claims to:
Owens Corning/Fibreboard Asbestos Personal Injury Trust
P.O. Box 1072
Wilmington, Delaware 19899-1072

Instructions for the Claim Form

File your claim more efficiently. Submit and manage your claim electronically through the Owens Corning/Fibreboard ("OCFB") Asbestos Personal Injury Trust's (the "Trust") website. Visit www.ocfbasbestostrust.com for more information.

Note: It is possible that claim data previously submitted to the Celotex Asbestos Settlement Trust, the Babcock & Wilcox Asbestos Settlement Trust, the USG Asbestos Settlement Trust and the Armstrong World Industries Asbestos Settlement Trust can be used to expedite the preparation and review of claims for the Trust. Doing so will reduce the work necessary to file a claim and minimize the time it takes to review the claim. Please visit the Trust's website (www.ocfbasbestostrust.com) for information on how to make use of this data. Presumptive Significant Occupational Exposure Occupation Ratings are available on the Trust's website www.ocfbasbestostrust.com .

Otherwise, complete this claim form as thoroughly and accurately as possible. Please type or print neatly. Should there be insufficient space to list all relevant information, please attach additional sheets. In addition to filing this form, please ensure the following are enclosed:

- Death Certificate (if applicable)
- Certificate of Official Capacity or other estate documentation (if personal representative is filing form) if applicable per state law
- Medical records as required by the Trust Distribution Procedures and as requested in instructions
- Proof of Owens Corning and/or Fibreboard Exposure, as applicable (i.e., qualifying exposure to OCFB Products/Operations, as defined below and as set out in the instructions)
- Documentation of Economic Loss (if applicable – see Part 8 below)
- Completed Form W-9 if using release that does not include W-9 language (if applicable)

Choice of Claim Process

Please choose the applicable claim process **(check only one)**:

☐ Expedited Review ("ER") (not available for Level VI, Lung Cancer 2, or Foreign Claims)
☐ Individual Review ("IR")

Please identify the applicable entity that you are claiming against **(check one or both)**:

☐ Owens Corning ("OC")
☐ Fibreboard ("FB")

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Representation

If counsel represents claimant, please print or type the following information:

1. Attorney Name: _______________________________ ____________________________ ____
(Last) (First) (MI)

2. Name of Law Firm: ____

3. Firm Address: ____
____

4. Attorney Phone: ( ) ______________ Fax: ( ) ______________ Email: ___________________

5. Paralegal or Contact Name: _____________________________ _________________________ ____
(Last) (First)
(MI)

6. Contact Phone: ( ) ______________ Fax: ( ) ______________ Email: ____________________

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Part 1: Injured Party Information

1. Name: _________________________________ ______________________________ ____
(Last) (First) (MI)

2. Social Security Number: ______-_____-_______

3. Gender: Male ______ Female ______ 4. Date of Birth: _______/_______/_______
(month) (day) (year)

5. Is injured party living? Yes_______ No _______

6. If injured party is deceased, please complete the following: **(Death Certificate must be enclosed)**

6a. Date of death: _______/_______/_______
(month) (day) (year)

6b. Was death asbestos-related? Yes _______ No _______

7. If injured party is living and not represented by counsel, please complete the following:

7a. Mailing address: ____
(street/PO Box)
____
(city/state/zip)

7b. Daytime Phone: ( ) _______- _______

7c. Email Address: ____

8. If injured party is deceased or has a personal representative or heir other than, or in addition to, his/her attorney, please indicate the following for the representative. **(Certificate of Official Capacity or other estate documentation must be enclosed if applicable per state law.)**

8a. Name: _________________________________ ______________________________ ____
(Last) (First) (MI)

8b. Social Security Number: _____-____- ______ , or Tax ID Number: ___________________

8c. Mailing Address: ____
(street/PO Box)
____
(city/state/zip)

8d. Daytime Phone: ( ) _______ - _________

8e. Email Address: ____

8f. Relationship to injured party: ____
(spouse, child, etc.)

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Part 2: Diagnosed Asbestos-related Injuries

1. Place an X next to the highest level (most serious) asbestos-related Disease Category that has been diagnosed for the injured party and for which medical documentation is attached to this claim form. See instructions for a list of specific medical criteria and records that must be enclosed for each Disease Category. **(Check only the most serious)**

	Level	Scheduled Disease
☐	**VIII**	**Mesothelioma**
☐	**VII**	**Lung Cancer I**
☐	**VI**	**Lung Cancer 2** (Individual Review Only)
☐	**V**	**Other Cancer** **(Please specify: __________________________________)**
☐	**IV**	**Severe Asbestosis** (ILO of 2/1 or greater, or asbestosis determined by pathology plus (a) TLC less than 65% or (b) FVC less than 65% plus FEVl/FVC ratio greater than 65%)
☐	**III**	**Asbestosis/Pleural Disease** (Bilateral Asbestos-Related Non-Malignant Disease plus (a) TLC less than 80% or (b) FVC less than 80% and FEV1/FVC ratio greater than or equal to 65%)
☐	**II**	**Asbestosis/Pleural Disease** (Bilateral Asbestos-Related Non-Malignant Disease)
☐	**I**	**Other Asbestos Disease** (Cash Payment Discount, not subject to the Payment Percentage)

2. Date of Diagnosis: ______/_______/_______
(month) (day) (year)

The claims must meet the relevant medical criteria and be supported by appropriate medical documentation as defined in the Asbestos Personal Injury Trust Distribution Procedures. The presumptive medical criteria for the Disease Categories set forth above are included in the instructions.

☐ For claims filed against OCFB or any other asbestos defendant in the tort system prior to the Petition Date (October 5, 2000), please check this box if you have a report of a diagnosing physician who conducted the physical exam of the claimant, or you have filed such a report with OCFB or another defendant in the tort system or another asbestos-related personal injury settlement trust. (see Sections 5.7(a)(1)(a) and 5.7(a)(1)(c) of the TDP)

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Part 3: Exposure to Asbestos Operations, Activities or Products

Proof of Significant Occupational Exposure ("SOE") to asbestos-related products as well as proof of OCFB Exposure *(i.e., qualifying exposure to OC and/or FB Products/Operations, as defined below and as set out in the instructions)* must be enclosed as required by Asbestos Personal Injury Trust Distribution Procedures sections 5.3 and 5.7(b). (See instructions) ***Please photocopy this section and list separately each company site, industry, and occupation combination upon which you rely to meet the exposure requirements of the TDP.***

"OC and/or FB Products/Operations" means asbestos or asbestos-containing products manufactured, produced, distributed, sold, fabricated, installed, released, maintained, repaired, replaced, removed, and/or handled by OC, FB or any entity, including an OC or FB contracting entity, for which OC or FB is responsible.

Please include detail concerning all asbestos exposure (not just OCFB Exposure) which you think is sufficient to meet the criteria for approval of the claim at the claimed disease level. List each site, industry and occupation combination separately.

*For OCFB Exposure, a list of approved OC and FB sites is available on the Trust website (**www.ocfbasbestostrust.com**). Please reference this list and enter the Approved OCFB Site Code in item #1 below.*

If the site where you are alleging exposure to OC and/or FB Products/Operations is not on the approved OCFB site list, provide independent documentation of meaningful and credible evidence of exposure to such OC and/or FB Products/Operations. This may be established by documentation including, but not limited to, the following:

- *An affidavit of the injured party (an example is included on the Trust website)*
- *An affidavit of a co-worker*
- *An affidavit of a family member in the case of a deceased claimant*
- *Invoices*
- *Construction or similar records*
- *Sworn statement, interrogatory answers, sworn work history, or deposition*

1. Site/Plant where exposure occurred:
   Be sure that the site list is consistent with the entity you are claiming against - OC or FB.

   Name of Site/Plant of Asbestos Exposure: ____

   Or, if this site is on the approved OCFB site list, enter the Site Code from Exhibit A (available on web)

   Site Code: ____________

   If a Site Code is entered, please skip to question 2, otherwise provide:

   City: ____

   State/Province: __________________ Country: ____________

   If this exposure involved products manufactured, produced, distributed, sold, fabricated, installed, released, maintained, repaired, replaced, removed, and/or handled by OCFB or any entity, including an OCFB contracting entity, for which OCFB is responsible, identify the products and provide the evidentiary basis for the claim that these products were at that site.
   ____

   ____

2. Date Exposure Began: _____/______ (month) (year) Date Exposure Ended: _____/______ (month) (year)

3. Occupation at Time of Exposure (*e.g.*, Boilermaker, Laborer, etc.): _________________________

4. Industry in which exposure occurred: _______ (Industry codes listed below)

   If Code 37 - Other, please describe: ___________________________________

Industry Codes

10. Asbestos mining	24. Petrochemical
11. Aerospace/aviation	25. Insulation
12. Asbestos abatement	27. Railroad
13. Automobile/mechanical friction	30. Shipyard-construction/repair
16. Chemical	31. Textile
17. Construction trades	32. Tire/rubber
18. Iron/steel	33. Utilities
19. Longshore	34. Asbestos products manufacturer
20. Maritime	36. Building occupant
21. Military	37. Other
23. Non-asbestos products manufacturing	

5. If your occupation does not appear on the list of Presumptive SOE Occupations Ratings list (available at www.ocfbasbestostrust.com.), please advance directly to question 6. If it does appear on the list, indicate circumstances of exposure to asbestos products or activities (check all applicable):

   ☐ Injured party handled raw asbestos fibers on a regular basis

   ☐ Injured party fabricated asbestos-containing products such that the injured party in the fabrication process was exposed on a regular basis to raw asbestos fibers

   ☐ Injured party altered, repaired or otherwise worked with an asbestos-containing product such that the injured party was exposed on a regular basis to asbestos fibers

   ☐ Injured party was employed in an industry or occupation such that the injured party worked on a regular basis in close proximity to workers who did one or more of the above three activities

   ☐ None of the above

6. If the injured party's occupation ***does not*** appear on the list of Presumptive SOE Occupations Ratings list, or "None of the above" was checked in question 5 above, provide a description of how the injured party was exposed to asbestos.

   ____

   ____

7. **Company Exposure** Every claimant must submit evidence of exposure to OC/FB asbestos products or activities.

   a. To demonstrate exposure to OC/FB products or activities, check the applicable box below. If you check box 5, answer Question 7(b). If any of the first four boxes are checked, proceed to question #8. (check one box only)

   ☐ 1. The site is on the relevant OC or FB approved site list, and the injured party worked there during the appropriate time period (if there is no date on the site list, please answer the question 7(b) below); or

   ☐ 2. Claimant's answer to Question #1 is the injured party's personal identification of exposure to OC or FB asbestos products/activities; or

☐ 3. Claimant's answer to Question #1 otherwise identifies OC or FB asbestos products/activities at this site (e.g. coworker affidavit), and also identifies the injured party by name; or

☐ 4. The answer to Question #1 provides evidence that OC or FB asbestos products or activities were at this site and further sets forth that the injured party worked at this site within a year of having demonstrated that the asbestos products or activities were present at the site; or

☐ 5. None of the above apply.

b. If the box 5 was checked, or if the box 1 was checked and there is no date on the site list, provide a description of the injured party's exposure to the type of asbestos products or activities that you have attributed to OC/FB at this site:
____
____
____
____

8. If this exposure is in support of *Exposure to an Occupationally Exposed Person* from Part 4, please enter the name of the occupationally exposed individual:

______________________________ ____________________________ ___
(Last) (First) (MI)

Part 4: Exposure from an Occupationally Exposed Person

Note: If a claimant alleges an asbestos-related disease resulting solely or in part from exposure to an occupationally exposed person, such as a family member, the claimant must seek Individual Review of his or her claim pursuant to Sections 5.3(b) and 5.5 of the Trust Distribution Procedures. See Choice of Claim Process box on first page of this claim form.

1. Is the claimant alleging an asbestos-related disease resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)?

   Yes______ No______

   If yes, Part 3 must also be completed for each occupationally exposed person.

2. Date exposure to other person began: ______/________ (month) (year)

3. Date exposure to other person ended: ______/________ (month) (year)

4. Relationship to occupationally exposed individual:

   ____
   (brother, son, spouse, etc.)

5. Social Security Number of occupationally exposed individual: _______-_______-_______

6. Describe how injured party was exposed through the occupationally exposed individual to the OCFB products or conduct:

   ____

   ____

   ____

   ____

Reminder: Part 3 <u>must</u> be completed for the occupationally exposed person. If the injured party also had direct, occupational exposure to asbestos, Part 3 must also be completed for that exposure.

Part 5: Litigation/Claims History

1. Has an asbestos-related lawsuit ever been filed on behalf of the injured party? Yes____ No____

   a. Was Owens Corning named as a defendant? Yes____ No____

   Was Fibreboard named as a defendant? Yes____ No____

   b. State in which the suit was originally filed: __________________

   c. Name of court in which the suit was originally filed: __________________________________

   d. Case number: ___________________________________

   e. Date the suit was originally filed: ______/______/________
   (month) (day) (year)

   f. Have you received money from Owens Corning or Fibreboard regarding this suit?
   Yes____ No____

   g. Did you sign a release releasing Owens Corning or Fibreboard regarding this suit?
   Yes____ No____

2. If the answer to question 1(a) above is No, in which state/jurisdiction would the claimant have elected to file suit against OCFB ? __________________ [see section 5.3(b)(2)]
   (state)

3. Was a tolling agreement for the injured party ever in effect with respect to the claim(s) against Owens Corning or Fibreboard? Yes____ No____

   a. Date the tolling agreement began: ______/______/________
   (month) (day) (year)

   b. Date the tolling agreement ended: ______/______/________
   (month) (day) (year)

If your answer to Question 3 is "Yes", please enclose a copy of the tolling agreement with this Claim Form.

Part 6: Financial Dependents

List any other persons who may have rights associated with this claim. Be sure to include the injured party's spouse and/or any other financial dependents who derive (or who derived at the time of diagnosis of the asbestos-related disease claimed) at least one-half of their financial support from the injured party. ***This must be completed for IR claims only.***

If additional space is required, please photocopy this page and insert after current page.

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Heir ☐ Other ______________________

4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Heir ☐ Other ______________________

4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Heir ☐ Other ______________________

4. Financially Dependent: ☐ Yes ☐ No

1. Name: ____ 2. Date of Birth: ______/______/_______
(Last) (First) (MI) (month) (day) (year)

3. Relationship: ☐ Spouse ☐ Child ☐ Heir ☐ Other ______________________

4. Financially Dependent: ☐ Yes ☐ No

Part 7: Smoking History

For each item, indicate whether the injured party has smoked. Please indicate the dates cigarettes or cigars were used, and the amount per day. Indicate fractional packs or fractional cigars as appropriate, *e.g.*, three and one-half packs would be entered as 3.5. ***This need only be completed for IR claims alleging disease Levels II through VII.***

1. Has the injured party ever **Smoked Cigarettes?** Yes_______ No_______

1a. From: ______/_______ (month) (year) To: ______/_______ (month) (year)

1b. Packs per day:_______ (use decimal)

1. Has the injured party ever **Smoked Cigars?** Yes_______ No_______

1a. From: ______/_______ (month) (year) To: ______/_______ (month) (year)

1b. Cigars per day:_______ (use decimal)

Part 8: Employment Information for Economic Loss

This is to be completed for IR claims only.

1. Current Employment Status of the injured party:
   - ☐ Full-time, outside the home
   - ☐ Full-time, within the home
   - ☐ Part-time, outside the home
   - ☐ Part-time, within the home
   - ☐ Retired
   - ☐ Disabled
   - ☐ Deceased

2. Amount of last annual wages: $______________________

3. Date of last wage received: ______/_______
   (month) (year)

(Enter current date if currently earning work-related compensation.)

If economic losses are being claimed, you must enclose an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Part 9: Signature Page

All claims must be signed by the claimant, or the person filing on his/her behalf (such as the personal representative or attorney).

If signed by the claimant or the personal representative, I (the claimant or personal representative) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge, under penalty of perjury, the information submitted is accurate and complete.

If signed by the claimant's counsel, Upon information and belief, I hereby certify, under penalty of perjury, that the information submitted is accurate and complete.

Signature of claimant, personal representative, or claimant's counsel.

Please print the name and relationship to the claimant of the signatory above.

Date: ______/______/_______
(month) (day) (year)

Please review your submission to ensure it is complete and includes the following documents as applicable.

- ☐ Death Certificate (if applicable)
- ☐ Certificate of Official Capacity or other estate documentation (if personal representative is filing form) if applicable per state law.
- ☐ Medical Records as required by the Trust Distribution Procedures and as requested in the instructions
- ☐ Proof of OCFB exposure and Significant Occupational Exposure as required in the Trust Distribution Procedures and requested in the instructions, including affidavits from the injured party or others.
- ☐ Copy of the tolling agreement (if applicable in Part 5)
- ☐ Documentation of Economic Loss (if Part 8 is applicable)

If you are filing an IR claim and have additional information (see TDP section 5.3(b)(2)) you want the Trust to consider in evaluating your claim, please include these documents with the Claim Form.