

# GREEN FORM

## Diet Drug Settlement With American Home Products Corporation

- Part I:** Matrix Compensation Benefits Claim Form  
(to be completed by Claimant or Claimant's Representative)
- Part II:** Doctor's Evaluation Form  
(to be completed by Physician)
- Part III:** Claimant's Lawyer Statement  
(to be completed if you are represented by an Attorney)
- Appendix:** Settlement Matrix Compensation Benefits Guide for  
Physicians, Attorneys and Class Members

Do not detach or separate bound Claim Forms.

To receive Matrix Compensation Benefits, you must complete the BLUE FORM in addition to this GREEN FORM.

### Part I — To the Claimant(s):

1. This form should be used if you believe that you are entitled to Matrix Compensation Benefits under the Diet Drug Settlement Agreement with American Home Products Corporation. These Benefits are described generally in the official notices authorized by the Court and in the "Settlement Matrix Compensation Benefits Guide for Physicians, Attorneys and Class Members," which is an Appendix to this form.

If you are the individual who used the diet drugs Pondimin® (Fenfluramine) and/or Redux™ (Dexfenfluramine) and who has a condition which you believe qualifies for a Matrix Compensation Benefit, state your name, birth date, Social Security Number and, if known, the Claim Number that you have received from the AHP Settlement Trust.

If you are making this Claim as the guardian, executor, administrator, or other legal representative of a living person or the estate of a deceased person, or as a Derivative Claimant, such as a spouse, child, dependent, parent, other relative or "significant other" of the person who used the diet drugs Pondimin® ("Fenfluramine") and/or Redux™ ("Dexfenfluramine") and who has (or had) a condition which you believe qualifies for a Matrix Compensation Benefit, state the name, birth date, and Social Security Number of the person who used the diet drugs and, if known, the Claim Number received from the AHP Settlement Trust relating to the Diet Drug Recipient.

\_\_\_\_\_  
(First Name of Diet Drug Recipient)

\_\_\_\_\_  
(Middle Initial)

\_\_\_\_\_  
(Last Name)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Birth Date MM/DD/YYYY)

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
(Social Security Number)

18300 - \_\_\_\_\_  
(Claim Number, if known)

**Remove the GREEN FORM label from the  
Notice Package, affix here and fill out all  
information above.**

Mail this form to:  
AHP Settlement Trust  
1100 E. Hector Street Suite 450  
Conshohocken, PA 19428

For assistance, call 1-800-386-2070  
Or access <http://www.settlementdietdrugs.com>







4. If you are submitting this form as a Derivative Claimant, (i.e., a spouse, parent, child, dependent, relative, or “significant other” of a Diet Drug Recipient), complete the information below:

a. (NOTE—Current and correct information is required for all Derivative Claimants. If there is information for more than one Derivative Claimant, check here  and then use a blank piece of paper or a photocopy of this question to provide the information for each applicable Derivative Claimant. Include that paper with this form. Be advised that a single benefit amount in accordance with Matrix A-2 or B-2 (See pages 17-18 of the Appendix) will be apportioned between all eligible Derivative Claimants.)

\_\_\_\_\_ (First Name)      \_\_\_\_\_ (Middle Initial)      \_\_\_\_\_ (Last Name)

\_\_\_\_\_ (Street Address)

\_\_\_\_\_ (City)      \_\_\_\_\_ (State)      \_\_\_\_\_ (Zip Code)

(\_\_\_\_) \_\_\_\_\_ (Daytime Area Code & Phone Number)      (\_\_\_\_) \_\_\_\_\_ (Evening Area Code & Phone Number)

\_\_\_\_\_ (E-mail Address, if any)

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Date of Birth MM/DD/YYYY)      \_\_\_\_\_ (Social Security Number)

b. Specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

- Spouse       Dependent, specify \_\_\_\_\_
- Parent       Other relative, specify \_\_\_\_\_
- Child       Significant other, specify \_\_\_\_\_

c. If you selected “Spouse” above, what is the current status of the relationship of the Derivative Claimant to the Diet Drug Recipient?

- Married     Divorced     Separated     Widowed

Date of the Marriage: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)





d. If the Derivative Claimant is a Spouse who is currently estranged from the Diet Drug Recipient, state the date of separation and/or divorce.

Date:     /     /                          
 (MM/DD/YYYY)

(Provide evidence of the date of separation or divorce, i.e., separation agreement or divorce decree.)

e. Identify the basis on which the Derivative Claimant is claiming “derivative” benefits.

- Loss of Consortium/Per Quod (e.g., loss of marital services and relationship)
- Loss of Support
- Loss of Service
- Other, explain: \_\_\_\_\_

**NOTE:** If you are completing this questionnaire as a Representative or Derivative Claimant, the following questions using the term “You” refer to the “Diet Drug Recipient.”

5. Check which Matrix Level of Severity (see Appendix pages 18-21) you believe you currently qualify for:

- Level I             Level II             Level III             Level IV             Level V

6. Check which Matrix (see Appendix pages 16-17) you believe you qualify for:

- Matrix A-1 (the full compensation Matrix)             Matrix B-1 (the reduced compensation Matrix)

7. State your age and the date on which you were diagnosed with the condition or experienced the event (e.g., date of surgery) which you believe qualifies you for payment at the Matrix Level set forth in the answer to Question #5:

Date of diagnosis/event:     /     /                                    Age at diagnosis/event: \_\_\_\_\_  
 (MM/DD/YYYY)

8. To the best of your knowledge, did you have the condition which you believe qualifies you for payment at the Matrix Level before you took Pondimin® and/or Redux™?

- Yes             No             Don’t Know

9. Are you represented by any lawyer in connection with this Claim?

- Yes             No

If you checked the box marked “Yes,” have your lawyer complete the Claimant’s Lawyer Statement (Part III, p. 15 of this GREEN FORM).

10. To complete the submission of your Claim, you must provide all (a) hospital reports of the admitting history and physical examinations, (b) cardiac catheterization reports, (c) hospital discharge summaries, (d) operation or surgery reports, (e) pathology reports, and (f) the written report and a copy of the videotape or disk of the Echocardiogram results which relate to the condition for which you seek compensation.







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