PINK FORM

Diet Drug Settlement With American Home Products Corporation

This PINK FORM is to be used by any Class Member who wants to accept the "Accelerated Implementation Option."

Completing and submitting this PINK FORM constitutes an agreement between the Claimant and American Home Products Corporation under which the Claimant agrees to accept the Accelerated Implementation Option.

Please print or type all responses. Completing this PINK FORM will entitle you to benefits which shall begin to be paid or provided as the Trial Court rules on the approval or non-approval of the Settlement regardless of whether the Settlement receives Final Judicial Approval. If you have retained a lawyer regarding your use of diet drugs, you should consult him or her about your options under the Settlement.

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1. Please complete the following information for the Diet Drug Recipient (the person who used the diet drugs).

____
(First Name) (Middle Initial) (Last Name)

____
(List all other names that you use or have used during the last ten years)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)__________ — __________ (________)__________ — __________
(Daytime Phone Number & Area Code) (Evening Phone Number & Area Code)

____
(E-mail Address, if any)

____
(Birth Date — Month, Day, Year) (Social Security Number)

____
Gender: ❒ Female ❒ Male

Remove label from mailing envelope and affix here.

Please return this form to:
Diet Drug Settlement
P.O. Box 7939
Philadelphia, PA 19101

2. **Are you completing this questionnaire as the "Representative Claimant" (i.e., estate, administrator, other legal representative, heir or beneficiary of a Diet Drug Recipient)?**

❐ No (please skip to Question 3) ❐ Yes (please complete the following:)

____
(First Name) (Middle Initial) (Last Name)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)__________—__________________(________)__________—__________
(Daytime Phone Number & Area Code) (Evening Phone Number & Area Code)

____
(E-mail Address, if any)

If you are representing a deceased's estate, please attach an official copy of the death certificate, a copy of any letters of administration or probate or surrogate certificate or complete the following:

Date of Death: ______________________________

Reason for lack of death certificate: ______________________________

If you are representing any other person as a Representative Claimant, please attach a copy of any order or other document appointing you the person's legal representative.

3. **Are you completing this form as a "Derivative Claimant" (i.e., a spouse, child, dependent, parent, other relative or "significant other" of a Diet Drug Recipient)?**

❐ No (please go to Question 5) ❐ Yes (please go to Question 4)

4. **a. Please provide the following information concerning each "Derivative Claimant." (If there is more than one, check here ❐ and either copy this section of the form or use a blank piece of paper to provide the information. Please staple that paper to this form.)**

____
(First Name) (Middle Initial) (Last Name)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)__________—__________________(________)__________—__________
(Daytime Phone Number & Area Code) (Evening Phone Number & Area Code)

____
(E-mail Address, if any)

____
(Birth Date — Month, Day, Year) (Social Security Number)

b. Please specify the relationship of the Derivative Claimant to the Diet Drug Recipient.

❒ Spouse ❒ Dependent, please specify______________________________
❒ Parent ❒ Other relative, please specify ___________________________
❒ Child ❒ Significant other, please 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 (Month/Day/Year): __________________________

d. If you, the Derivative Claimant, are currently estranged from the Diet Drug Recipient, please state the date of separation and/or divorce.

Date: ______________________________

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

e. Please 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, please explain: ____
____
____
____

NOTE: Each Claimant (including Representative and/or Derivative Claimants) must complete this form and sign the Acceptance of Terms and Conditions of Accelerated Implementation Option.

5. **Are you represented by any lawyer in connection with this claim?**

❒ Yes ❒ No

6. **If you answered "Yes" to the previous question, please provide the following information:**

____
(Law Firm Name)

____
(Attorney's Name)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)_____—_____________________ (________)_____—_____________________
(Daytime Phone Number & Area Code) (Fax Number)

____
(E-mail Address, if any)

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[1]."

7. **Please state whether you were prescribed and took the following Diet Drugs:**

Pondimin® (Fenfluramine) ❒ Yes ❒ No
Redux™ (Dexfenfluramine) ❒ Yes ❒ No

8. **Indicate the total period of time that you took Pondimin® and/or Redux™:**

60 days or less ________ 61 days or more ________

9. **Please state the total period of time that you used each of the following diet drugs:**

Pondimin® _______________ Redux™ _______________

10. **Please provide the information requested in subparts A, B, or C. You should only respond to one subpart of this question.** ***You may supply copies of the requested records with this form or, if you wish, supply them to the Claims Administrators at a later time.***

a. **If the diet drug (Pondimin® and/or Redux™) was dispensed by a pharmacy, please identify the pharmacy name, address and telephone number.**

____
(Pharmacy Name)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)_____—_____________________
(Telephone Number & Area Code)

[1]The "Diet Drug Recipient" is the person who took Pondimin®, Redux™, and/or "Fen-Phen."

[If there is more than one pharmacy that dispensed diet drugs, make a copy or copies of this page and provide the information for each such pharmacy and attach those additional sheets to this form, if necessary.]

Please supply a copy of the pharmacy prescription dispensing records (e.g., prescription printouts, pharmacy records, prescription forms) from each pharmacy which should include the medicine's name, quantity, frequency, dosage, and number of refills prescribed, prescribing physicians name, assigned prescription number, original fill date and each subsequent refill date. If you do not have or do not wish to obtain a copy of such records yourself check here ❒ and complete the authorization attached to this form. The Claims Administrators will use the authorization to obtain a copy of your pharmacy records.

OR

b. **If the diet drug (Pondimin® and/or Redux™) was dispensed directly by a physician or weight loss clinic, or the pharmacy record(s) is unobtainable,** state the name of each physician who prescribed the diet drug, and the address and telephone number of that physician:

____
(Prescribing Physician's Name)

____
(Street Address)

____
(City) (State) (Zip Code)

(________)__________—_________________________________
(Telephone Number & Area Code)

(If there was more than one physician or weight loss clinic that prescribed diet drugs, please make a copy or copies of this page, provide information concerning each such additional physician or weight loss clinic on those copies and attach them to this form.)

Please supply a copy of the medical record(s) reflecting the prescription and/or dispensing of the diet drugs. This must include records to identify the Diet Drug Recipient, the diet drug name, the date(s) prescribed, the dosage and duration for which the drug was prescribed or dispensed. If you do not have a copy of such medical records or you do not wish to obtain copies yourself check here ❒ and complete the authorization attached to this form. The Claims Administrators will use that authorization to obtain a copy of the medical records.

OR

c. **If, and only if, the pharmacy record(s) or medical record(s) are unobtainable,** check here ❒ and have your prescribing physician or dispensing pharmacist complete the attached form Declaration of Prescribing Physician or Dispensing Pharmacy.

11. Have you had an Echocardiogram[2] after you first started using diet drugs?

❒ Yes ❒ No

If yes, state the date(s) of each Echocardiogram(s) and the name and address of each physician who performed the Echocardiogram or reported the results to you.

Date	Name of Physician/Clinic	Address of Physician/Clinic

If you have in your possession a copy of the Echocardiogram report(s) and videotape or disk of the Echocardiogram, please check this box ❒ and attach a copy of each report, and video tape or disk of the Echocardiogram. If you do not, please check here ❒ and sign the Medical Authorization form so that the Trustees and/or Claims Administrators in the Diet Drug Settlement can obtain a copy of any Echocardiogram report or video tape or disk.

12. If you answered "Yes" to Question 11, please answer the following to the best of your knowledge:

a. Did any show mild or greater aortic regurgitation? ❒ Yes ❒ No
b. Did any show moderate or greater mitral regurgitation? ❒ Yes ❒ No
c. Did any show mild mitral regurgitation? ❒ Yes ❒ No
d. Don't know ❒

13. Would you like to receive information about the Compassionate and Humanitarian or Financial Hardship provisions described in the Official Court Notice?

❒ Yes ❒ No

14. Would you like to receive information concerning reimbursement benefits for all or part of the cost of certain privately-obtained echocardiograms?

❒ Yes ❒ No

15. Please state whether you elect to receive cash benefits or medical services[3] if you qualify. Such benefits or services will only become available to you if the Claims Administrators determine that you are eligible. You may select only one option.

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[2] An Echocardiogram is a test in which sound waves are passed through the chest to result in a video image of the heart and its valves. It should not be confused with an "electrocardiogram" in which sensors are placed at various locations in the body and a paper readout is generated.

[3] The medical services shall be determined by the Trustees and may include comprehensive physical examinations, chest x-rays, electrocardiograms, standard laboratory testing, medically-appropriate echocardiograms, and/or medically-supervised nutritional counseling.

❒ I elect to receive $6,000 in cash if the Claims Administrators determine that I took the diet drugs Pondimin® and/or Redux™ 61 days or more and I am diagnosed as "FDA Positive" by the end of the Screening Period, or $3,000 in cash if the Claims Administrators determine that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as "FDA Positive" by the end of the Screening Period.

OR

❒ I elect to receive $10,000 in heart valve related medical services if the Claims Administrators determine that I took the diet drugs Pondimin® and/or Redux™ 61 days or more and I am diagnosed as "FDA Positive" by the end of the Screening Period, or $5,000 in heart valve related medical services if the Claims Administrators determine that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as "FDA Positive" by the end of the Screening Period.

16. **Do you believe that you have any medical condition which qualifies for payment on the Compensation Matrices described in the Official Court Notice?**

    ❒ Yes ❒ No

    Note: If you answered "Yes" to the previous question, you and a Board-Certified Cardiologist and/or Cardiothoracic Surgeon (and in some instances, a Board-Certified Pathologist, Neurologist or Neurosurgeon) must additionally complete the separate Matrix Benefits Compensation Claim Form—the GREEN FORM—in order to obtain the benefit.

Acceptance of Terms and Conditions of Accelerated Implementation Option

17. **Individual Settlement Agreement and Incorporation of Nationwide Settlement Agreement.** By signing and submitting this form, the undersigned acknowledges and agrees that:

    a. he/she has received, read (or has had read to him/her) and understands the Notice of Settlement;

    b. he/she willingly and is freely entering into this Individual Agreement with American Home Products Corporation by signing and submitting this form to resolve, settle and release any and all Settled Claims he/she (or the party he/she represents) has or may have, now or in the future, whether known, unknown or unknowable, against American Home Products Corporation and other Released Parties defined in the nationwide Class Action Settlement Agreement ("Settlement Agreement"), and only those parties. The Settlement Agreement, including, without limitation its benefits and its release provisions, is incorporated by reference into this Individual Agreement as if fully set out at length. Under this Individual Settlement Agreement, which is an exercise of the Accelerated Implementation Option provided for in that Settlement Agreement, the undersigned parties and American Home Products Corporation will have all

the same rights, benefits, entitlements, releases and obligations to one and other as the benefits, releases and rights accorded to Class Members and to American Home Products Corporation, as the case may be, under the nationwide Class Action Settlement Agreement except as provided in the Settlement Agreement; and

c. he/she understands that the Individual Agreement will be effective prior to the Final Judicial Approval Date of the Settlement and, if the Settlement Agreement does not receive Final Judicial Approval or is terminated for any reason, this Individual Agreement, including the Release and Covenant Notice to Sue, will continue to be effective and binding.

18. Waiver of certain Opt-out rights. By submitting this form and agreeing to accept the Accelerated Implementation Option, the undersigned knowingly waive all Intermediate and "Back-end" Opt-out rights provided by the Settlement Agreement, as described in the Notice of Settlement, and agree(s) not to object to approval of the Settlement by any court or to appeal from any such approval.

19. Release and Covenant Not to Sue.

a. In consideration of the obligations of American Home Products Corporation ("AHP") under the Accelerated Implementation Option ("AIO") as set forth in Section V of the Nationwide Class Action Settlement Agreement with AHP (the "Settlement Agreement") pending in or approved by the United States District Court for the Eastern District of Pennsylvania, I, the undersigned claimant, individually and for my heirs, beneficiaries, agents, estate, executors, administrators, personal representatives, successors and assignees, and/or, if I claim as a representative of the person who use Pondimin® and/or Redux™ or of the person who has a derivative claim arising out of the use of Pondimin® and/or Redux™, in that capacity, whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, hereby expressly **release and forever discharge, and agree not to sue**, AHP and all other Released Parties (as defined in the Settlement Agreement) as to all Settled Claims (as defined in the Settlement Agreement). I understand that certain principles of law, such as those reflected in statutes like Section 1542 of the California Civil Code and in the common law of many states, provide that a release may not extend to claims which I do not know or suspect to exist. I am aware that I may discover claims presently unknown or unsuspected, or facts in addition to or different from those which I now believe to be true with respect to the matters released herein which may be applicable to this settlement. Nevertheless, **I hereby knowingly and voluntarily relinquish the protections of Section 1542 and all similar federal or state laws, rights, rules or legal principles that may be applicable, as follows**. I fully, finally and forever settle and release any and all Settled Claims, including assigned claims, whether known or unknown, asserted or unasserted, regardless of the legal theory, existing now or arising in the future out

of or relating to the purchase, use, manufacture, sale, dispensing, distribution, promotion, marketing, clinical investigation, administration, regulatory approval, prescription, ingestion, and labeling of Pondimin® and/or Redux™, alone or in combination with any other substance, including, without limitation, any other drug, dietary supplement, herb, or botanical that I may have against any Released Party.

b. For purposes of this Release and Covenant Not to Sue, the terms "Settled Claims" and "Released Parties" are defined as set forth in the Settlement Agreement, which is incorporated by reference.

c. I agree that this AIO Individual Agreement settles any lawsuit previously initiated by me, if any, asserting any Settled Claim against AHP or any other Released Party, and I stipulate and agree to the dismissal of all such claims, suits and proceedings, with prejudice and without costs and agree to cooperate as reasonably requested in order to effectuate such a dismissal.

20. Confidentiality. I hereby authorize disclosure of the information contained in this form and any other documents supplied in connection with my claim to such persons as may be reasonably necessary for purposes of processing any claim and providing any benefits under the Settlement Agreement.

21. Declaration under Penalty of Perjury. The persons signing below acknowledge and understand that this form is an official document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the Claims Administrators is equivalent to filing it with a court. Each declares under penalty of perjury that all of the information provided in this form is true and correct to the best of his/her knowledge, information and belief.

____

(Signature of Diet Drug Recipient, if Living) (Date)

____

(Signature(s) of Legal Representative(s) of Diet Drug Recipient, if any) (Date)

____

(Signature(s) of Claiming Spouse, Parent, Child, Dependent, Other Relative, or "Significant Other," if any) (Date)

(NOTE—If necessary, you may copy this page and have any person who has to sign this form separately sign. If you do, please attach the signed copied page to this form before sending it in.)

Remember, in order to complete the submission of your Registration, you must supply the following to the Claims Administrators:

1. You must supply the Claims Administrators with written proof of the amount of Pondimin® and/or Redux™ which was dispensed for your use by your drugstore(s), doctor(s) or healthcare facility(s). If you supply the names, addresses, and telephone numbers for your drugstore(s), doctor(s) or healthcare facility(s) as described in question Number 10, and complete the Medical Records Authorization, you fulfill this requirement.

2. If you are submitting this form as a legal representative or guardian you must supply the Claims Administrators with a copy of the Order or other document authorizing you to serve as a legal representative or guardian.

3. If you have had an Echocardiogram after you first began using Pondimin® and/or Redux™, you must supply the Claims Administrators with a report of each Echocardiogram and the videotape or disk of the Echocardiogram, if you have them in your possession. If you do not have them in your possession, you must sign and return the attached medical records authorization form.

4. If you claim Matrix compensation benefits, you and your doctor must complete the Matrix Compensation Benefits Claim Form—the GREEN FORM—and return it to the Claims Administrators.

   The address of the Claims Administrators is:

   Claims Administrators
Diet Drug Settlement
P.O. Box 7939
Philadelphia, PA 19101

5. If you change your address, please notify the Claims Administrators as soon as possible.

Medical Records Authorization

This will authorize you to furnish copies of all echocardiographic recordings and reports in your possession (including written reports and Echocardiographic video tapes and disks), pharmacy prescription dispensing records (including information concerning the diet drug name, quantity, frequency, dosage and number of refills, prescribing physician's name, original fill date and each subsequent refill date) and prescribing or dispensing physician medical records (including information identifying the undersigned patient, the diet drug name, the date(s) prescribed, the dosage, and duration the drug was dispensed) concerning ____,
(Name of Diet Drug Recipient)
whose date of birth is ____
(Date of Birth of Diet Drug Recipient)
and whose social security number is ____.
(Social Security Number of Diet Drug Recipient)

You are authorized to release the above records/recordings to the Trustees and/or Claims Administrators in the Diet Drug Settlement. The entity requesting the records will pay reasonable charges made by you to supply copies of such records/or disks.

Please forward the above records to:

Claims Administrators
Diet Drug Settlement
P.O. Box 7939
Philadelphia, PA 19101

This authorization does not authorize you to disclose anything other than the items referenced above to anyone.

____
(Date) (Claimant or Claimant's Legal Representative)

For use ONLY IF you marked Box 10 (c).

Diet Drug Settlement With American Home Products Corporation

Declaration of Prescribing Physician or Dispensing Pharmacy

Use this form ONLY IF your pharmacy record(s) and medical records(s) are unobtainable as described in Question Number 10 above. This form is to be completed, if necessary, by the doctor who prescribed Pondimin® and/or Redux™, or the pharmacy that dispensed Pondimin® and/or Redux™.

I prescribed/dispensed Pondimin® and/or Redux™ for the following patient:

____
(Name)

____
(Birth Date—If known) (Social Security Number —If known)

I am:

❒ The physician who prescribed Pondimin® and/or Redux™ to the patient identified above.
❒ The pharmacist who dispensed Pondimin® and/or Redux™ to the patient identified above.

I prescribed or dispensed Pondimin® and/or Redux™ to the patient identified above as set forth in the following chart:

Drug Name	Dosage	Approximate Start Date			Approximate End Date			Number of Pills Per Day
		Month	Day	Year	Month	Day	Year	

This Declaration is an official document sanctioned by the Court before which the Diet Drug Settlement is pending, and submitting it to the Claims Administrators is equivalent to filing it with a court. I declare under penalty of perjury that all of the information provided in this Declaration is true and correct to the best of my knowledge, information and belief.

____
(Date) (Signature)

____
(Printed Name)