

CLAIMS FORM

The Claims Package, including this Claims Form, must be submitted no later than July 1, 2008, on behalf of all Enrolled Program Claimants, including Unrepresented (*pro se*) Enrolled Program Claimants, ("Claimant") in the Resolution Program outlined in the Settlement Agreement of November 9, 2007 (the "Agreement").

INSTRUCTIONS

1. Counsel for Claimants, and all *pro se* Claimants, must complete this Claims Form.
2. Attachment A to this Claims Form must be completed by a Claimant only if the Claimant *has not completed and supplied a Profile Form*, as defined in Section 17.1.71 of the Settlement Agreement. If a Claimant has completed a Profile Form, it must be included in the Claims Package.

A. VIOXX USER INFORMATION

1. Name	Last	First	Middle Initial
2. Current Address	Street		
	City	State	Zip Country
3. Telephone Number	() -		4. Date of Birth ____/____/____ (Month/Day/Year)
5. Social Security Number	- -		6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
7. Date of Death of product user (if applicable)	____/____/____ (Month/Day/Year)		
8. Do you claim Vioxx caused the death?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Any Other Names Used or by which Vioxx User has been known, including but not limited to maiden name:			

B. REPRESENTATIVE CLAIMANT INFORMATION FOR DECEASED OR INCAPACITATED CLAIMANTS

10. Does the Vioxx User have a Representative?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, Complete Items 11 -14) (If No, Skip to Section C)	11. Relationship to Vioxx User
12. Name	Last	First Middle Initial
13. Address	Street	
	City	State Zip Country
14. Social Security Number	- -	

C. COUNSEL INFORMATION

15. Counsel Name	Last	First	Middle
16. Firm Name			
17. Current Address	Street		
	City	State	Zip
18. Telephone #		19. Fax	20. Email

D. LAWSUIT INFORMATION

21. Has a civil action been filed in court alleging injuries as a result of the Product User's use of Vioxx? <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Court/Jurisdiction	23. Case Caption
24. Docket Number	
25. Did Claimant seek tolling at any time under the Federal MDL Tolling Agreement for the Product User's injuries allegedly arising from use of Vioxx? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Date of First Submission under the Federal MDL Tolling Agreement	__/__/____ (Month/Day/Year)
27. Date Submitted Claimant Profile Form (If never submitted, you must complete Attachment A).	__/__/____ (Month/Day/Year)

E. INJURY INFORMATION

28. Check the primary injury Claimant is alleging or has alleged previously in a Complaint or Profile Form from Product User's use of Vioxx and indicate the date of occurrence (select only one Injury Type as the primary injury).	
Primary Injury Types	Date (Month/Day/Year)
<input type="checkbox"/> Myocardial Infarction ("MI")	__/__/____
<input type="checkbox"/> Myocardial Infarction, Fatal	__/__/____
<input type="checkbox"/> Sudden Cardiac Death ("SCD")	__/__/____
<input type="checkbox"/> Ischemic Stroke ("IS")	__/__/____
<input type="checkbox"/> Ischemic Stroke, Fatal	__/__/____
29. If applicable, check the secondary injury Claimant is alleging or has alleged previously in a Complaint or Profile Form from Product User's use of Vioxx and indicate the date of occurrence (select only one Injury Type as the secondary injury).	
Secondary Injury Types	Date (Month/Day/Year)
<input type="checkbox"/> Myocardial Infarction ("MI")	__/__/____
<input type="checkbox"/> Myocardial Infarction, Fatal	__/__/____
<input type="checkbox"/> Sudden Cardiac Death ("SCD")	__/__/____
<input type="checkbox"/> Ischemic Stroke ("IS")	__/__/____
<input type="checkbox"/> Ischemic Stroke, Fatal	__/__/____

30. Is Claimant applying to receive Extraordinary Injury Payments pursuant to Section 4.2 of the Settlement Agreement? Yes No

F. CLAIMS PACKAGE MATERIALS

You must submit all Claims Package materials required by Section 1.3 of the Settlement Agreement. Indicate that you have included or will include the following in your submission:

- All PME Records specified in Exhibit 1.3.1 to the Settlement Agreement.
- This Claims Form.
- A Profile Form, as defined in Section 17.1.71 of the Settlement Agreement.

Dated: _____

Signature of Counsel: _____

ATTACHMENT A

ATTENTION: THIS ATTACHMENT MUST BE COMPLETED BY CLAIMANTS WHO HAVE NOT PREVIOUSLY COMPLETED AND SUBMITTED A PLAINTIFF PROFILE FORM OR PLAINTIFF FACT SHEET IN THE COORDINATED PROCEEDINGS OR A CLAIMANT PROFILE FORM UNDER THE TOLLING AGREEMENT IN THE MDL.

A. MEDICAL BACKGROUND OF PRODUCT USER

If at any time *prior* to the alleged injury, the Vioxx User underwent any of the following procedures, was diagnosed with any of the following conditions, or used any of the following substances, check all that apply and complete all additional information requested for each:

<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Coronary Bypass Surgery	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Coronary Artery Disease	Height at Time of Alleged Event: _____ Weight at Time of Alleged Event: _____	
<input type="checkbox"/>	Vascular Disease		
<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Migraine Headaches
<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	Stroke	Type (e.g., cigarettes, cigars, pipe, chewing tobacco): _____ Amount Smoked or Used Per Day (for cigarettes, packs/day; for cigars, cigars/day, etc.): _____ - _____ Number of Years Used: _____ Date Quit (if applicable): _____	
<input type="checkbox"/>	Transient Ischemic Attack		
<input type="checkbox"/>	Carotid Artery Disease		
<input type="checkbox"/>	Carotid Artery Procedure (e.g., Endarterectomy or Stenting)		
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Birth Control
<input type="checkbox"/>	High Blood Pressure	Dates of Use: _____	
<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Hormone Replacement Therapy
<input type="checkbox"/>	Illegal Drugs	Dates of Use: _____	

B. FAMILY HISTORY

At any time, have any of the Vioxx User's parents or siblings experienced either of the following:

<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Stroke
Relatives (Specify Mother, Father, Sister or Brother)		Relatives (Specify Mother, Father, Sister or Brother)	
Age(s) at Heart Attack		Age(s) at Stroke	

C. PRODUCT USAGE

Identify the dates (month, day, and year) that the Vioxx User began to take and stopped taking Vioxx and, for each period, the dosage taken:

Date Began	Date Stopped	Dosage
__/__/____ (Month/Day/Year)	__/__/____ (Month/Day/Year)	
__/__/____ (Month/Day/Year)	__/__/____ (Month/Day/Year)	
__/__/____ (Month/Day/Year)	__/__/____ (Month/Day/Year)	
__/__/____ (Month/Day/Year)	__/__/____ (Month/Day/Year)	

CERTIFICATION AND AUTHORIZATION

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Claims Form is true and correct to the best of my knowledge, information and belief.

Claimant's Signature	_____		
Printed Name	_____	Date	__/__/____ (Month/Day/Year)