GREEN FORM

Diet Drug Settlement Program
Claim Form for Incremental Matrix Compensation Benefits

Instructions

1. This Green Form should be used if you believe that you are entitled to Incremental Matrix Compensation Benefits under the Diet Drug Settlement Agreement with American Home Products Corporation. Matrix Compensation 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. Incremental Matrix Compensation Benefits mean the incremental dollar amount, if any, by which the Matrix Grid Amount for a higher Matrix Level for a Progression Matrix Level Condition exceeds the Matrix payment previously made to or on behalf of the Eleventh Amendment Class Member, pursuant to Section IV.C.3 of the Settlement Agreement.

2. There are three parts to this Green Form and an informational Appendix:

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 a Board-Certified Physician**
Part III:	Claimant's Lawyer Statement to be completed if Claimant is represented by an Attorney
Appendix:	Settlement Matrix Compensation Benefits Guide for Physicians, Attorneys and Class Members

3. This Green Form must be submitted to the Claim Administrator no later than four years from the date on which the Claimant was first diagnosed as having the Progression Matrix Level Condition upon which the Claim for Incremental Matrix Compensation Benefits is based.

4. There are two ways to submit your Green Form and supporting documentation to the Claim Administrator:

   (a) Online: Follow the instructions on the Claim Administrator website, www.dietdrugsettlementprogram.com, Submit a Claim page for the quickest and easiest way to submit your Claim electronically.

   (b) By Mail: Use this address to submit your Claim by mail:

Diet Drug Settlement Program
P.O. Box 85006
Richmond, VA 23285

For assistance, call 1-800-386-2070

Part I-To the Claimant(s):

If you are the individual who used the diet drugs Pondimin® (Fenfluramine) and/or Redux™ (Dexfenfluramine) and who has a Progression Matrix Level condition which you believe qualifies for an Incremental Matrix Compensation Benefit, state your name, birth date, Social Security Number, gender and, if known, your DDR Number. Your DDR Number is the number that was previously assigned to you by the AHP Settlement Trust and that DDR Number has not changed.

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 Progression Matrix Level condition which you believe qualifies for an Incremental Matrix Compensation Benefit, state the name, birth date, and Social Security Number of the person who used the diet drugs and, if known, the DDR Number. The DDR Number is the number that was previously assigned to the Diet Drug Recipient by the AHP Settlement Trust and that DDR Number has not changed.

Name Diet Drug Recipient	Last	First	Middle

Address	Street	City	State	Zip

Daytime Telephone		**Evening Telephone**	
Email Address			
Date of Birth	_____ /_____ / _____ (MM DD YYYY)	**Social Security Number**	_____ (Enter numbers only)
Gender		**DDR Number, if known**	18300- _____

1. **If the Diet Drug Recipient seeks Incremental Matrix Compensation Benefits, this GREEN FORM must be completed and submitted no later than four years from the date on which the Diet Drug Recipient was first diagnosed as having the Progression Matrix Level Condition upon which the Claim is based.**

   If the Diet Drug Recipient qualified for and had been paid a Matrix Compensation Benefit in the past, then the right to seek incremental payments has been preserved if the Diet Drug Recipient's medical condition has worsened and the change places your Claim on a higher level of the payment Matrix.

2. **If you are submitting this Form as the Representative of the estate of the Diet Drug Recipient, or on behalf of a Diet Drug Recipient who has become incapacitated, complete the information below:**

Name of Representative	Last	First	Middle

Address	Street	City	State	Zip

Daytime Telephone		**Evening Telephone**	
Email Address			
Social Security Number	_____ (Enter numbers only)		
Diet Drug Recipient's Status	☐ Deceased	☐ Legally Incapacitated	

Part I-To the Claimant(s):

Representative Plaintiff's Relationship to Diet Drug Recipient	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Administrator ☐ Executor ☐ Guardian Other: _____

NOTE-If you previously provided a copy of the court order or other document appointing you as the personal representative of the Diet Drug Recipient to the AHP Settlement Trust, the Claim Administrator should be able to access that document. However, if you have not previously provided to the AHP Settlement Trust or to the Claim Administrator a copy of the court order or other document appointing you as the personal representative of the Diet Drug Recipient, you must attach or include a copy of your court approval or other authorization to represent the Diet Drug Recipient in this Settlement with your completed GREEN FORM. Check whichever box is applicable:

☐ I have already provided the requested documentation previously or on another form and there is no change.

☐ A copy of my court approval or other authorization to represent the Diet Drug Recipient is attached.

3. 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 if submitting your claim by mail or scan and upload it to the Claim Administrator with your supporting claim documents. Be advised that a single benefit amount in accordance with Matrix A-2 or B-2 (See page 23 of the Green Form Appendix) will be apportioned between all eligible Derivative Claimants.)

Name of Derivative Claimant	Last	First	Middle	
Address	Street	City	State	Zip
Daytime Telephone		**Evening Telephone**		
Email Address, if any				
Date of Birth	_____ /_____ / _____ (MM DD YYYY)	**Social Security Number**	_____ (Enter numbers only)	

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

☐ Spouse ☐ Parent ☐ Child

☐ Dependent, specify: _____

☐ Other relative, specify: _____

☐ Significant other, specify: _____

Part I-To the Claimant(s):

(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 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 of Separation and/or Divorce: _____ /_____ / _____
(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 Green Form Appendix pages 23-27) you believe you currently qualify for:

☐ Level II ☐ Level III ☐ Level IV ☐ Level V

NOTE: Class Members no longer can make a claim for Severity Level I benefits.

6. Check which Matrix (see Green Form Appendix pages 21-23) 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. 19 of this GREEN FORM).

Part I-To the Claimant(s):

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.**

In the space below, list the medical providers who have provided medical treatment related to your Claim.

Name of Physician, Clinic or Hospital	Address of Physician, Clinic or Hospital	Date(s) of Treatment, Service of Admission
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)
		_____ /_____ / _____ (MM DD YYYY)

If there are additional physicians, clinics or hospitals, check here ☐ and use an additional sheet to list them. Remember to include that sheet with this Form if submitting your claim by mail or scan and upload it to the Claim Administrator with your supporting claim documents.

Part I-To the Claimant(s):

11. Subrogation Lien or Claim Information. Claimants are required to provide the below information in order to determine whether a valid subrogation claim has been asserted concerning the above referenced Matrix Compensation Claim.

(a) Medicare Eligibility

Are you entitled to benefits under Medicare for any reason, including without limitation, that (a) you are age 65 or older, (b) you have certain disabilities that make you eligible regardless of your age, or (c) you have permanent kidney failure that requires dialysis or a kidney transplant?

☐ Yes ☐ No

If you answered Yes to Question 11(a), please provide your Health Insurance Claim Number (HICN): _____

If you answered No, proceed to Questions 11(b)-(e).

(b) Asserted Claims

Has any insurer, HMO, government agency (including Medicare or Medicaid), or other third party payor who paid or provided healthcare benefits asserted a Subrogation Lien or Claim **with respect to any potential recovery related to the conditions which are the basis for the Matrix Compensation Claim you submitted for benefits** under the Nationwide Class Action Settlement Agreement with American Home Products Corporation?

☐ Yes ☐ No (if No, proceed to Question 11(e))

Provide the following information about the third party payor or payors (if more than one, see Question 11(d)):

Name				
Address	Street	City	State	Zip
Amount of Claim	**$** _____			
Communications	Include copies of all communications you have received from the third party payor with respect to the subrogation lien or claim and return them with this Form if submitting your claim by mail or scan and upload it to the Claim Administrator with your supporting claim documents.			

(c) Do you contest the lien or claim?

☐ Yes ☐ No

If you answered Yes to Question 11(c), describe why: _____

NOTE: The Diet Drug Settlement achieved a settlement with many private insurance companies such that an assertion of a lien or claim by such a private insurance company that had settled all claims will not be valid. The Claim Administrator will assess whether any asserted lien or claim is not valid.

Part I-To the Claimant(s):

(d) Are there additional third party payors who have asserted a lien or claim?

☐ Yes ☐ No

(If there is more than one third party payor, provide the name(s), full address(es) and amount(s) of claim(s) on a separate sheet and return it with this Form if submitting your claim by mail or scan and upload it to the Claim Administrator with your supporting claim documents.). Also include copies of all communications you have received from any additional third party payors with respect to the subrogation lien or claim and return them with this Form if submitting your claim by mail or scan and upload it to the Claim Administrator with your supporting claim documents.

(e) Has Medicare paid for any of your medical care for conditions related to the basis for your Matrix Compensation Claim?

☐ Yes ☐ No

12. The undersigned hereby consent(s) to the disclosure of the information contained herein to the extent necessary to process this Claim for Settlement Benefits. Each person signing below agrees to cooperate with the Claim Administrator and to provide any necessary medical record authorizations and releases for the Claim Administrator to gather information needed to substantiate or audit the Claim. Each person signing below acknowledges and understands that this Form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the Claim Administrator is equivalent to filing it with a Court. After reviewing the information which has been supplied on this Form by a Board-Certified Physician (Part II) and, if applicable, by an attorney (Part III), each person declares under penalty of perjury that the information provided in this Form is true and correct to the best of his/her knowledge, information and belief.

13. The undersigned hereby consents to the disclosure of the Diet Drug Recipient's personally identifying information along with information from this Form to third parties identified on this Form or who otherwise assert a subrogation lien, claim, or other interest in this claim and to the Centers for Medicare & Medicaid Services and the Department of Health & Human Services so the Claim Administrator can adjudicate all relevant claims.

***How to Sign this Claim Form*:** If submitting your Claim online, sign by typing your name in the Signature space below. Sign by hand if submitting your Claim by mail.

Signature of Diet Drug Recipient, if Living			
Name of Diet Drug Recipient	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		
Signature(s) of Legal Representative(s) of Diet Drug Recipient, if any			

Part I-To the Claimant(s):

Name of Legal Representative	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		
Signature(s) of Derivative Claimant, if any			
Name of Derivative Claimant	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		
Signature(s) of Derivative Claimant, if any			
Name of Derivative Claimant	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		
Signature(s) of Derivative Claimant, if any			
Name of Derivative Claimant	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		

PART II-To the Board-Certified Physician:

Important Information to Claimants Regarding Part II of This Form

Part II of this Form must be completed by a Board-Certified Cardiologist or a Board-Certified Cardiothoracic Surgeon. However, if the Claim is based upon the Diet Drug Recipient developing endocardial fibrosis, then you may, if you prefer, have a Board-Certified Pathologist complete Part II regarding the existence of the pathological criteria for endocardial fibrosis. If the Claim is based upon the determination of the functional outcome that a Diet Drug Recipient has or had six months after a stroke, then, if you prefer, a Board-Certified Neurologist or Board-Certified Neurosurgeon may also complete the questions in Part II of the Form that concern that outcome.

Part II-To the Board-Certified Physician:

Part I of this Form identifies an individual who was prescribed and ingested the diet drugs Pondimin® ("Fenfluramine") and/or Redux™ ("Dexfenfluramine") .and who has a condition that may qualify the patient, his or her legal representatives and/or members of the family for payment as part of the Nationwide Class Action Settlement with American Home Products Corporation.

A Board-Certified Cardiologist or Board-Certified Cardiothoracic Surgeon must complete Part II of this Form. (The response to Question F.11 may be supplied by a Board-Certified Neurologist or Board-Certified Neurosurgeon, or based upon information supplied by such specialists. The response to Question L.6 may be supplied by a Board-Certified Pathologist, or based upon information supplied by such specialist.)

In completing the Form you may consider, rely upon and use the patient's Echocardiograms, medical records and reports, hospital records or reports, the patient's medical history or other sources of information you regularly and routinely use in your practice.

Please certify below that the patient either has or does not have a given condition to a reasonable degree of medical certainty. The conditions that are relevant to the determination of this Claim are defined by reference to well-accepted, published criteria, which are excerpted in the Settlement Matrix Compensation Benefits Guide for Physicians, Attorneys and Class Members, which are set forth in the Appendix.

A claimant who qualifies for a particular Matrix payment, by virtue of a properly interpreted Echocardiogram showing the required levels of regurgitation and/or complicating factors, after exposure to Pondimin® and/or Redux™, shall not be disqualified from receiving that Matrix payment if a subsequent Echocardiogram shows that the required levels of regurgitation and/or complicating factors are no longer present.

A. Medical Background: What is your name, office address, and telephone number?

Name	Last	First	Middle	
Address	Street	City	State	Zip
Daytime Telephone		**Email**		

Check whether you are:

☐ A Board-Certified Cardiologist ☐ A Board-Certified Cardiothoracic Surgeon

☐ Other (Must be Board-Certified) _____

PART II-To the Board-Certified Physician:

Check whether you have level 2 training in echocardiography as specified in the "Recommendations of the American Society of Echocardiography Committee on Physician Training in Echocardiography."[1]

☐ Yes ☐ No

B. Patient Information:

State the name of the patient (Diet Drug Recipient) for whom you are providing the information contained in this Form.

Name of Diet Drug Recipient	Last	First	Middle

C.

1. Did the above-named patient have an Echocardiogram which was conducted in accordance with the standards and criteria as outlined in Feigenbaum[2] (1994) or Weyman[3] (1994)?

   ☐ Yes ☐ No

2. If the answer to Question C.1 if "Yes," state the date when the Echocardiogram was performed.

   ___ __ _ / _____ / __ ____

   (MM DD YYYY)

3. Based on your review of the Echocardiogram tape or disk, does the above-named Diet Drug Recipient have the following conditions as defined by Singh[4]? (Check each that applies):

   (a) For **mitral** regurgitation, the following determined in any apical view:

   ☐ Mild mitral regurgitation, defined as (1) either the regurgitant jet area/left atrial area ("RJA/ LAA") ratio is more than 5% or the mitral regurgitant jet height is greater than 1 cm from the valve orifice, and (2) the RJA/LAA ratio is less than 20%.

   ☐ Moderate mitral regurgitation, defined as regurgitant jet area in any apical view equal to or greater than 20% of the left atrial area but less than or equal to 40% (20%-40% RJA/LAA).

   ☐ Severe mitral regurgitation, defined as > 40% RJA/LAA.

   ☐ None of the above.

   (b) For **aortic** regurgitation, the following determined in the parasternal long-axis view or in the apical long-axis view, if the parasternal long-axis view is unavailable:

   ☐ Mild aortic regurgitation, defined as regurgitant jet diameter equal to or greater than 10% but less than 25% of the outflow tract height (10%-24% jet height ("JH")/left ventricular outflow tract height ("LVOTH")).

   ☐ Moderate aortic regurgitation, defined as 25%-49% JH/LVOTH.

   ☐ Severe aortic regurgitation, defined as > 49% JH/LVOTH.

   ☐ None of the above.

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[1] A.S. Pearlman, *et al., Guidelines for Oplimal Physician Training in Echocardiography: Reco111me11da!ions of the A111erica11 Sociely of Echocardiography Commilteefor Physician Training in Echocardiography,* 60 Am. J. Cardiol. 158-163 (1987).

[2] H. Feigenbaum, *Eclzocardiography* 68-133 (5th ed. 1994).

[3] A. E. Weyman, *Principles and Practice of Echocardiography* 75-97 (2d ed. 1994).

[4] J. P. Singh, *et al., Prevalence and Clinical Determinants of Mitra/, Tricuspid and Aortic Regurgitation (The Framingham Heart Study),* 83 Am. J. Cardiol. 897-902 (1999).

PART II-To the Board-Certified Physician:

D. Based on your review of the Echocardiogram tape or disk (or the results of any cardiac catheterization or surgical examination), does the above-named Diet Drug Recipient have any of the following conditions:

1. Congenital Aortic Valve Abnormalities: Unicuspid, Bicuspid or Quadricuspid aortic valve; ventricular septal defect associated with aortic regurgitation?

   ☐ Yes ☐ No

2. Aortic dissection involving the aortic root and/or aortic valve?

   ☐ Yes ☐ No

3. Aortic sclerosis at the time that the Diet Drug Recipient was first diagnosed with mild or greater aortic regurgitation if he or she was 60 or older at that time?

   ☐ Yes ☐ No

4. Aortic root dilation >5.0 cm?

   ☐ Yes ☐ No

5. Aortic stenosis with an aortic valve area <1.0 square centimeter by the Continuity Equation?

   ☐ Yes ☐ No

6. Congenital mitral valve abnormalities: Parachute valve or cleft of the mitral valve associated with atrial septal defect?

   ☐ Yes ☐ No

7. Mitral valve prolapse defined as a condition where (a) the Echocardiogram videotape or disk includes the parasternal long-axis view and (b) that Echocardiographic view shows displacement of one or both mitral leaflets >2 mm above the atrial-ventricular border during systole, and >5 mm leaflet thickening during diastole, as determined by a Board-Certified Cardiologist[5]?

   ☐ Yes ☐ No

8. Chordae tendinae rupture or papillary muscle rupture, or acute myocardial infarction associated with acute mitral regurgitation?

   ☐ Yes ☐ No

9. Mitral annular calcification?

   ☐ Yes ☐ No

[5] L.A. Freed, *et al., Prevalence and Clinical Outcomes of Mitra/ Valve Prolapse*, 341 New Eng. J. Med. I, 2 (1999).

PART II-To the Board-Certified Physician:

10. M-Mode and 2-D Echocardiographic evidence of rheumatic heart valves (doming of the anterior leaflet and/or anterior motion of the posterior leaflet and/or commissural fusion), except where a Board- Ce1tified Pathologist has examined mitral valve tissue and determined that there was no evidence of rheumatic valve disease?

☐ Yes ☐ No

E. To the best of your knowledge, has the above-named Diet Drug Recipient had the following:

1. Heart valve surgery to repair or replace the mitral valve prior to Pondimin® and/or Redux™ use?

☐ Yes ☐ No

2. Heart valve surgery to repair or replace the aortic valve prior to Pondimin® and/or Redux™ use?

☐ Yes ☐ No

3. Bacterial endocarditis prior to Pondimin® and/or Redux™ use?

☐ Yes ☐ No

4. Mild or greater aortic regurgitation confirmed by echocardiography prior to Pondimin® and/or Redux™ use?

☐ Yes ☐ No

5. Moderate or greater mitral regurgitation confirmed by echocardiography prior to Pondimin® and/or Redux™ use?

☐ Yes ☐ No

6. Carcinoid tumor of a type associated with aortic and/or mitral valve lesions?

☐ Yes ☐ No

7. History of daily use of methysergide or ergotamines for a continuous period of longer than 120 days?

☐ Yes ☐ No

8. A diagnosis of Systemic Lupus Erythematosus and valvular regurgitation and/or abnormalities of a type associated with Systemic Lupus Erythematosus?[6]

☐ Yes ☐ No

9. A diagnosis of rheumatoid arthritis and valvular regurgitation and/or abnormalities of a type associated with rheumatoid arthritis?[7]

☐ Yes ☐ No

[6] *Harrison's Principles of Internal Medicine* 1878 (14th ed. 1998).
[7] *Id.* at 1885.

PART II-To the Board-Certified Physician:

F. To the best of your knowledge, has the above-named Diet Drug Recipient developed the following conditions <u>after</u> the date on which the patient first used Pondimin® and/or Redux™:

1. Bacterial endocarditis associated with either mild or greater aortic regurgitation and/or moderate or greater mitral regurgitation? [If "Yes," documentation supporting bacterial endocarditis must be provided.]

   ☐ Yes ☐ No

2. Pulmonary Hypertension secondary to severe aortic regurgitation with a peak systolic pulmonary pressure >40 mm Hg[8] measured by cardiac catheterization or with a peak systolic pulmonary artery pressure >45 mm Hg measured by Doppler Echocardiography, at rest, utilizing standard procedures[9][10] assuming a right atrial pressure of 10 mm Hg?

   ☐ Yes ☐ No

3. Pulmonary Hypertension secondary to moderate or greater mitral regurgitation with peak systolic pulmonary artery pressure >40 mm Hg measured by cardiac catheterization or with a peak systolic pulmonary artery pressure >45 mm Hg[11] measured by Doppler Echocardiography, at rest, utilizing standard procedures assuming a right atrial pressure of 10 mm Hg?

   ☐ Yes ☐ No

4. Abnormal left ventricular end-systolic dimension >50 mm[12] by M-mode or 2-D echocardiography or abnormal left ventricular end-diastolic dimension >70[13] mm as measured by M-mode or 2-D echocardiography?

   ☐ Yes ☐ No

5. Abnormal left atrial supero-inferior systolic dimension >5.3 cm[14] (apical four chamber view) or abnormal left atrial antero-posterior- systolic dimension >4.0 cm (parasternal long-axis view) measured by 2-D directed M-mode or 2-D echocardiography with normal sinus rhythm using sites of measurement recommended by the American Society of Echocardiography?[15]

   ☐ Yes ☐ No

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[8] Braunwald, *Heart Disease: Textbook of Cardiovascular Medicine* 796-98 (1997).
[9] Feigenbaum, *supra* at 201-02.
[10] Chan, K-L., *et al., Comparison of Three Doppler Ultrasound Methods in the Prediction of Pulmona,y Arte1y Disease,* 9 J. Am. Coll. Cardiol. 549-554 (1987).
[11] Braunwald, *supra...*
[12] Bonow R.O., *et al., Guidelines for the Manageme/11 of Patients With Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee 011 Management of Patients With Valvular Heart Disease),* 32 J. Am. Coll. Cardiol. 1510-14 (1998).
[13] *Id.*
[14] Weyman, *supra* at 1290-1292.
[15] Henry, W.L. *et al., Report of the American Society of Echocardiography Committee on Nomenclawre and Standards in Two-dimensional Echocardiography,* 62 Circulation 212-17 (1980).

PART II-To the Board-Certified Physician:

6. Abnormal left ventricular end-systolic dimension greater than or equal to 45 mm[16] by M-mode or 2-D Echocardiogram?

☐ Yes ☐ No

7. Arrhythmias, defined as chronic atrial fibrillation/flutter that cannot be converted to normal sinus rhythm, or atrial fibrillation/flutter requiring ongoing medical therapy, either of which are associated with left atrial enlargement? (Abnormal left atrial supero-inferior systolic dimension >5.3 cm[17] (apical four chamber view) or abnormal left atrial antero-posterior systolic dimension >4.0 cm (parasternal long-axis view) measured by 2-D directed M-mode or 2-D echocardiography.)

☐ Yes ☐ No

8. Ejection fractions as follows:[18]

50%-60%	☐ Yes	☐ No	30%-34%	☐ Yes	☐ No
40%-49%	☐ Yes	☐ No	<30%	☐ Yes	☐ No
35%-39%	☐ Yes	☐ No			

9. Surgery to repair or replace the aortic and/or mitral valve(s) after use of Pondimin® and/or Redux™?

☐ Yes ☐ No

10. Severe regurgitation and the presence of ACC/AHA Class I indications for surgery to repair or replace the aortic[19] and/or mitral[20] valve(s) where such surgery was not performed?

☐ Yes ☐ No

(a) Was valvular repair/replacement surgery medically indicated but the patient declined to consent to surgery?

☐ Yes ☐ No

(b) Was valvular repair/replacement surgery medically contraindicated?

☐ Yes ☐ No

If your answer to Question F.10 was "Yes," supply (at end of form) or attach a written statement from the attending Board-Certified Cardiologist or Board-Certified Cardiothoracic Surgeon supported by medical records regarding the recommendation made to the patient concerning valvular surgery with the reason that surgery was not performed.

[16] Bonow, *supra* at 1533-35.
[17] Weyman, *supra* at 1290-1292.
[18] Bonow, *supra.*
[19] *Bonow,supra at* 1510-14.
[20] Bonow, *supra* at 1533-35.

PART II-To the Board-Certified Physician:

11. Stroke due to (a) bacterial endocarditis contracted after use of Pondimin® and/or Redux™, or (b) chronic atrial fibrillation with left atrial enlargement as defined in Question F.5 above, or (c) valvular repair and/or replacement surgery which has resulted in a permanent condition which meets the criteria for the following functional levels of the AHA Stroke Outcome Classification System,[21] determined six months or later after the event:

(a) Functional Level II ☐ Yes ☐ No

(b) Functional Level III ☐ Yes ☐ No

(c) Functional Level IV ☐ Yes ☐ No

(d) Functional Level V ☐ Yes ☐ No

12. A peripheral embolus due to bacterial endocarditis and/or as a consequence of atrial fibrillation with left atrial enlargement as defined above which resulted in:

(a) Severe impairment to the kidneys, defined as chronic severe renal failure requiring hemodialysis or Continuous Abdominal Peritoneal Dialysis for more than six months.

☐ Yes ☐ No

(b) Severe impairment to the abdominal organs, defined as impairment requiring intra-abdominal surgery.

☐ Yes ☐ No

(c) Severe impairment to the extremities, defined as impairment requiring amputation of a major limb.

☐ Yes ☐ No

G. Does the above-named Diet Drug Recipient have New York Heart Association Functional Class symptoms as follows:

1.	**Class I**	☐ Yes	☐ No	**3.**	**Class III**	☐ Yes	☐ No
2.	**Class II**	☐ Yes	☐ No	**4.**	**Class IV**	☐ Yes	☐ No

H. Did the above-named Diet Drug Recipient have valvular repair or replacement surgery and have one or more of the following complications either during surgery, within 30 days after surgery, or during the same hospital stay as surgery:

1. Renal failure, defined as chronic, severe renal failure requiring regular hemodialysis or Continuous Abdominal Peritoneal Dialysis (CAPD) for greater than six months following aortic and/or mitral valve replacement surgery?

☐ Yes ☐ No

[21] M. Kelley-Hayes, *et al., The American Heart Association Stroke Outcome Classification,* 29 Stroke 1274-80, 1275 (1998). (Note: approved by the American Heart Association Science Advisory and Coordinating committee.)

PART II-To the Board-Certified Physician:

2. Peripheral embolus following surgery resulting in severe permanent impairment of the kidneys, abdominal organs, or extremities? NOTE: Severe permanent impairment of the kidneys means chronic. severe renal failure requiring hemodialysis or continuous abdominal peritoneal dialysis for more than six months. Severe impairment of the abdominal organs means impairment requiring intra-abdominal surgery. Severe impairment of the extremities means impairment requiring amputation of a major limb.

   ☐ Yes ☐ No

3. Quadriplegia or paraplegia resulting from cervical spine injury during valvular heart surgery?

   ☐ Yes ☐ No

I. Did the above-named Diet Drug Recipient have valve repair or replacement surgery and have:

1. Post-operative endocarditis, mediastinitis or sternal osteomyelitis, any of which required reopening of the median sternotomy for treatment?

   ☐ Yes ☐ No

2. A post-operative serious infection defined as HIV or Hepatitis C within six months of surgery as a result of blood transfusion associated with the surgery?

   ☐ Yes ☐ No

J. Did the above-named Diet Drug Recipient have valvular repair or replacement surgery and require a second surgery through the sternum within 18 months of the initial surgery due to prosthetic valve malfunction, poor fit, or complications reasonably related to the initial surgery?

☐ Yes ☐ No

K. Did the above-named Diet Drug Recipient have valvular repair or replacement surgery and have a left ventricular ejection fraction of< 40% at any time six months or later after the valvular repair or replacement surgery?

☐ Yes ☐ No

If your answer to Question K was "Yes," an Echocardiogram report and Echocardiogram tape or disk performed and interpreted in accordance with the standards and criteria outlined in Question C.1 above must be furnished.

PART II-To the Board-Certified Physician:

L. Did the above-named Diet Drug Recipient have one or more of the following:

1. A heart transplant?

   ☐ Yes ☐ No

2. Irreversible pulmonary hypertension secondary to valvular heart disease defined as peak-systolic pulmonary artery pressure >50 mm Hg[22] (by cardiac catheterization), at rest, following repair or replacement surgery of the aortic and/or mitral valve(s)?

   ☐ Yes ☐ No

3. A persistent non-cognitive state[23] caused by a complication of valvular heart disease (e.g., cardiac arrest) or valvular repair/replacement surgery?

   ☐ Yes ☐ No

   If the individual has such a condition, supply a detailed statement of the attending Board-Certified Cardiologist or Board-Certified Cardiothoracic Surgeon supported by medical records setting forth the basis for your opinion that the persistent non-cognitive state was caused by a complication of valvular heart disease or valvular repair/replacement surgery.

4. Death resulting from a condition caused by valvular heart disease or valvular repair/replacement surgery?

   ☐ Yes ☐ No

   Supply a detailed statement of the attending Board-Certified Cardiologist or Board-Certified Cardiothoracic Surgeon supported by medical records setting forth your opinion that the patient's death resulted from a condition caused by valvular heart disease and/or valvular repair/ replacement surgery.

5. Ventricular fibrillation or sustained ventricular tachycardia which results in hemodynamic compromise?

   ☐ Yes ☐ No

6. Endocardial Fibrosis

   (a) Diagnosed by

      (1) Endomyocardial biopsy that demonstrates fibrosis and a cardiac catheterization that demonstrates restrictive cardiomyopathy or

      (2) Autopsy that demonstrates endocardial fibrosis; **AND**

   (b) **Other causes of endocardial fibrosis have been excluded, such as:** dilated cardiomyopathy, myocardial infarction, amyloid, Loeffler' s endocarditis, endomyocardial fibrosis as defined in Braunwald (involving one or both ventricles, commonly involving the chordae tendineae, with partial obliteration of either ventricle commonly present),[24] focal fibrosis secondary to valvular regurgitation, e.g. 'jet lesions," fibrosis secondary to catheter instrumentation, and hypertrophic cardiomyopathy with septal fibrosis?

[22] Braunwald, *supra* at 596-98.
[23] Adelman, G., *Encyclopedia of Neuroscience* 268 (1987).
[24] Braunwald, *supra* at 1433-34.

PART II-To the Board-Certified Physician:

This Form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement and submitting it to the Claim Administrator is equivalent to filing it with a Court. I declare under penalty of perjury that the information provided in this Form is correct to the best of my knowledge, information and belief.

***How to Sign this Claim Form*:** If submitting Part II of the Green Form online, sign by typing your name in the Signature space below. Sign by hand if submitting Part II of the Green Form by mail.

Signature of Board-Certified Physician			
Name of Board-Certified Physician	Last	First	Middle
Date of Signature	_____ /_____ / _____ (MM DD YYYY)		

FOR USE WITH WRITTEN STATEMENTS

PART III – CLAIMANT'S LAWYER STATEMENT

If the Claimant checked the box marked "Yes" in Part I, Question #9, the Claimant's lawyer should complete this statement and submit it with this Green Form.

If submitting this Claim electronically on the Claim Administrator website, https://www.DietDrugSettlementProgram.com, scan and upload any additional documents requested below with this Green Form and the supporting materials. For claims submitted by mail, include attorney-related documents with this Green Form in hard copy.

1. Provide the following information about "Your Client":

Last	First	Middle

2. Provide the following information about yourself.

Law Firm Name				
Name of Attorney	Last	First	Middle	
Address	Street	City	State	Zip
Daytime Telephone		**Evening Telephone**		
Email Address				

3. Include a copy of the contingency fee agreement between yourself and Your Client.

4. State the amount of out-of-pocket costs incurred by you in your representation of Your Client for his/her diet drug claim. (Include a copy of your cost sheet with this Form.)

$_____

5. Has a subrogation lien or claim been asserted with respect to Your Client's right to receive benefits under the Diet Drug Settlement? ☐ **Yes** ☐ **No**

Name of Subrogee				
Address	Street	City	State	Zip

Does the Claimant contest the lien? ☐ Yes ☐ No

If yes, describe the lien and the basis for the context on a separate sheet and include it with this Form.

This Form is an official Court document sanctioned by the Court that presides over the Diet Drug Settlement, and submitting it to the Claim Administrator is equivalent to filing it with a Court. I declare under penalty of perjury that all of the information provided in this Form is true and correct to the best of my knowledge, information and belief.

***How to Sign this Claim Form*:** If submitting your Claim online, sign by typing your name in the Signature space below. Sign by hand if submitting your Claim by mail.

Attorney's Signature	

PART III – CLAIMANT'S LAWYER STATEMENT

Date of Signature	_____ /_____ / _____ (MM DD YYYY)

For assistance call 1-800-386-2070, or access the Diet Drugs Settlement website at https://www.DietDrugSettlementProgram.com