

AHP Settlement Trust Subrogation Form

Subrogation Lien or Claim Information for Payment

Due to Partial Refund of Fees Previously Withheld from Matrix Payment

NAME OF CLAIMANT: _____ **CLAIM NUMBER:** _____

DIRECTIONS: Claimants who may be entitled to payment of Matrix Compensation Benefits previously withheld 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.

The Trust cannot complete the processing of any Payment, where due, until this form is properly completed and returned.

PART I: ASSERTED CLAIMS

Has any insurer, HMO, government agency, 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 Benefits you received under the Nationwide Class Action Settlement Agreement with American Home Products Corporation, which Subrogation Lien or Claim is currently unresolved? (Please check the appropriate box below.){1]

YES (If YES, answer questions 1 - 4 below) **NO** (If the answer is NO, proceed to Question 4)

1. Provide the following information about the third party payor or payors:

Name

Address

City

State

Zip Code

\$ _____
Amount of Claim

2. Does the Claimant contest the lien or claim? _____ YES _____ NO

If you answered "YES" to Question 2, describe why: _____

3. Are there additional third party payors who have asserted a lien or claim? _____ YES _____ NO
(If there is more than one third party payor, please provide the name(s), full address(es) and amount(s) of claim(s) on a separate sheet and return it with this form.)

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4. Have you received any benefits from Medicare or has Medicare paid for any of your medical care?[1] YES NO

[1] Please note that it is your responsibility to notify Medicare if you received any Medicare benefits for or related to any medical condition forming the basis for your Claim.

PART II: CERTIFICATION

Consent to Disclosure/Certification of Claimant (All Forms Must Be Signed)

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 Trust can adjudicate all relevant claims.

The person(s) signing below acknowledges and understands that this form and any attachments to it are official documents sanctioned by the United States District Court for the Eastern District of Pennsylvania which presides over the Nationwide Class Action Settlement Agreement with American Home Products Corporation, and submitting it to the AHP Settlement Trust is equivalent to filing it with the Court.

Each person declares under penalty of perjury that all of the information provided in this form and any attachments is true and correct to the best of his/her knowledge, information and belief

Signature and printed name of the Diet Drug Recipient/Claimant

Date

Exhibit 3a (page 2 of (2))