

CERTIFICATION OF EXEMPTION FROM MEDICARE PROCEDURE															
<p>Class Members who may be Medicare beneficiaries and who qualify for Matrix benefits are subject to a procedure to address potential claims by Medicare to reimburse it for medical expenses paid for the Class Members. Under that procedure, the Trust will have an extension of time to issue a Final Determination on claims by such Class Members. The purpose of this Form is to provide Class Members entitled to receive Matrix Compensation Benefits, and who were 65 years or older at the time of any medical service or procedure relating to the claimant's valvular heart disease, the means to claim an exemption from such an extension of time for the Trust to issue a Final Determination. If the Class Member can truthfully certify, by completing and signing this Form and timely returning it to the AHP Settlement Trust, either (1) that Medicare has not paid for any of the Class Member's relevant medical services or procedures; or (2) that any such payments by Medicare have already been reimbursed by the Class Member, no extension of time under the Medicare procedure for the Trust to issue a Final Determination will be granted.</p>															
INSTRUCTIONS															
<ol style="list-style-type: none"> 1. The Class Member and the Class Member's attorney, if the Class Member is represented, must read this Form carefully. Print or type all information. 2. Complete Section A of this Form (Identifying Information) for the Class Member and the Class Member's attorney, if represented. 3. If, as stated in the certification below, Medicare has not paid for any of the Class Member's relevant medical services or procedures, the Class Member may complete Section B of this Form. 4. In order to be eligible for the exemption from the Medicare procedures, Class Members must return the completed Form, including the certification, to: AHP Settlement Trust, P.O. Box 7939, Philadelphia, PA 19101, no later than 30 days from the date of the transmittal letter accompanying this form. 															
A. IDENTIFYING INFORMATION															
Name of Class Member	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 50%;"></td> <td style="border-bottom: 1px solid black; width: 5%;"></td> <td style="border-bottom: 1px solid black; width: 45%;"></td> </tr> <tr> <td style="font-size: small;">First Name</td> <td style="font-size: small;">MI</td> <td style="font-size: small;">Last Name</td> </tr> </table>						First Name	MI	Last Name						
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Address of Class Member	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="3" style="border-bottom: 1px solid black; height: 15px;"></td> </tr> <tr> <td colspan="3" style="font-size: small;">Street Address</td> </tr> <tr> <td style="border-bottom: 1px solid black; width: 60%;"></td> <td style="border-bottom: 1px solid black; width: 15%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> </tr> <tr> <td style="font-size: small;">City</td> <td style="font-size: small;">State</td> <td style="font-size: small;">Zip Code</td> </tr> </table>						Street Address						City	State	Zip Code
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Social Security Number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 40%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> <td style="border-bottom: 1px solid black; width: 50%;"></td> </tr> <tr> <td style="font-size: small;">- - - - -</td> <td style="font-size: small;">-</td> <td style="font-size: small;">-</td> </tr> </table>				- - - - -	-	-	Claim Number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 100%;"></td> </tr> </table>						
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Name of Attorney (if any)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 50%;"></td> <td style="border-bottom: 1px solid black; width: 5%;"></td> <td style="border-bottom: 1px solid black; width: 45%;"></td> </tr> <tr> <td style="font-size: small;">First Name</td> <td style="font-size: small;">MI</td> <td style="font-size: small;">Last Name</td> </tr> </table>						First Name	MI	Last Name						
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Name of Law Firm	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 100%;"></td> </tr> <tr> <td style="font-size: small;">Law Firm</td> </tr> </table>				Law Firm										
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Attorney's Telephone Number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 40%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 40%;"></td> </tr> <tr> <td style="font-size: small;">- - - - -</td> <td style="font-size: small;">-</td> <td style="font-size: small;">-</td> </tr> </table>				- - - - -	-	-	Attorney's Facsimile Number	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 40%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 40%;"></td> </tr> <tr> <td style="font-size: small;">- - - - -</td> <td style="font-size: small;">-</td> <td style="font-size: small;">-</td> </tr> </table>				- - - - -	-	-
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Attorney's Email Address	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 100%;"></td> </tr> <tr> <td style="font-size: small;">Email</td> </tr> </table>				Email										
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B. CLAIMANT CERTIFICATION AND AGREEMENT

By my signature below, I hereby certify under penalty of perjury that the following is true and correct:

1. One of the following statements, which I have marked with an "X", is true and correct:

No medical services and/or procedures relating to the heart valve condition(s) which serve as the basis of my Matrix claim were paid for, in whole or in part, by Medicare.

-OR-

Although Medicare has paid, in whole or in part, for medical services and/or procedures relating to the heart valve condition(s) which serve as the basis of my Matrix claim, I have reimbursed Medicare for the full extent of such payments.

2. I understand that the submission of this form to the AHP Settlement Trust (the "Trust") shall be equivalent to filing it with the United States District Court for the Eastern District of Pennsylvania.

3. I understand and acknowledge, by my signature below, that I (and each of my respective heirs, executors, successors and assigns (collectively "Obligors")) shall be obligated to reimburse the Trust and Wyeth for any and all claims, suits or demands asserted against either of the Trust or Wyeth by Medicare or by any private person on behalf of Medicare arising out of or relating to the payment of medical expenses or the provision of medical services by Medicare or the failure of Wyeth or the Trust to pay Medicare, including the cost of investigating and defending against such Medicare Claims, suits or demands, and including any settlement thereof. I further understand and acknowledge that the Obligors shall be obligated to cooperate as reasonably requested by the indemnitee in such investigation and defense. I acknowledge that the Medicare Secondary Payer Act may permit recovery of double the amount of such expenses paid by Medicare, and agree that the foregoing indemnity includes the amount of any such double recovery or any other penalty or interest imposed. I further acknowledge that the United States District Court for the Eastern District of Pennsylvania has retained continuing and exclusive jurisdiction to administer, supervise, and enforce the Settlement Agreement and this Certification.

4. I have had the opportunity to consult with my attorney identified above, or to retain an attorney to advise me, and make this certification voluntarily and with full knowledge of the consequences of my actions.

Signature: _____
Class Member

Date: ____/____/____
(month) (day) (year)