







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

- Spouse
- Parent
- Child
- Dependent, specify \_\_\_\_\_
- Other relative, specify \_\_\_\_\_
- Significant other, 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: \_\_\_\_\_  
(MM/DD/YYYY)

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

Date: \_\_\_\_\_  
(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: Each Claimant (including Representative and/or Derivative Claimants) must sign the Declaration under Penalty of Perjury on page 7 of this BLUE FORM (making copies if necessary) and submit it with this form.**

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

- Yes
- No

**6. If you answered "Yes" to Question #5, provide the following information:**

\_\_\_\_\_  
(Law Firm Name)

\_\_\_\_\_ (Attorney's First Name)      \_\_\_\_\_ (Middle Initial)      \_\_\_\_\_ (Last Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_ (City)      \_\_\_\_\_ (State)      \_\_\_\_\_ (Zip Code)

(\_\_\_\_\_) \_\_\_\_\_ (Daytime Area Code & Phone Number)      (\_\_\_\_\_) \_\_\_\_\_ (Fax Area Code & 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.”<sup>1</sup>**

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

Pondimin® (Fenfluramine)     Yes     No

Redux™ (Dexfenfluramine)     Yes     No

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

**(If you took both drugs, add together the period of time you used each drug to determine the total period of use.)**

60 days or less       61 days or more

**9. State the total number of days that you used each of the following diet drugs:**

Pondimin® \_\_\_\_\_ days

Redux™ \_\_\_\_\_ days

**You bear the ultimate responsibility for providing records to substantiate the total number of days you used Pondimin® and/or Redux™.**

**10. You must provide the information requested below.**

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

\_\_\_\_\_  
(Pharmacy Name)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

(\_\_\_\_\_) \_\_\_\_\_  
(Area Code and Phone Number)

**[If there was more than one pharmacy that dispensed the diet drugs Pondimin® and/or Redux™, make a copy or copies of this page and provide the information for each such pharmacy and include those additional sheets with this form.]**

**Provide a copy of the pharmacy prescription dispensing records (e.g., prescription printouts, pharmacy records, prescription forms) from each pharmacy, which should include the medication name, quantity, frequency, dosage and number of refills prescribed, prescribing physician’s name, assigned prescription number, original fill date and each subsequent refill date.**

**OR**

<sup>1</sup> The “Diet Drug Recipient” is the person who took Pondimin®, Redux™, and/or the drug combination commonly known as “Fen-Phen.”





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:

\_\_\_\_\_ (First Name of Prescribing Physician) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last Name)

\_\_\_\_\_ (Name of Weight Loss Clinic, if applicable)

\_\_\_\_\_ (Street Address)

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

(\_\_\_\_\_) \_\_\_\_\_ (Area Code & Telephone Number)

**[If there was more than one physician or weight loss clinic that prescribed and/or dispensed the diet drugs Pondimin® and/or Redux™, make a copy or copies of this page and provide the information for each such physician or weight loss clinic and include those additional sheets with this form.]**

**Provide a copy of the medical record(s) reflecting the prescription and/or dispensing of the diet drugs. This must include records that 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, and only if, the pharmacy record(s) or prescribing physician’s medical record(s) are unobtainable, check here  and have your prescribing physician or dispensing pharmacist complete the attached Declaration of Prescribing Physician or Dispensing Pharmacy.**

**11. Have you had an Echocardiogram<sup>2</sup> 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.

<u>Date</u>	<u>Name of Physician/Clinic</u>	<u>Address of Physician/Clinic</u>
____/____/_____ (MM/DD/YYYY)	_____	_____
____/____/_____ (MM/DD/YYYY)	_____	_____
____/____/_____ (MM/DD/YYYY)	_____	_____

If you are seeking benefits based on the results of this Echocardiogram(s), you must attach a copy of each Echocardiogram report and include the videotape or disk of the Echocardiogram as part of your Claim submission.

<sup>2</sup> 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 on the body and a paper readout is generated.





**12. If you answered “Yes” to Question #11, 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

If you answered “Yes” to Questions #12.a, #12.b, or if you checked the box for #12.d, you must submit a GRAY FORM or GREEN FORM to complete your Claim.

If you answered “Yes” to Question #12.c, you should file a GRAY FORM to preserve your future rights under the Settlement Agreement. (See page 8, Item 6 for a more detailed explanation of the GRAY FORM.)

**13. If you would like to receive information about the Compassionate and Humanitarian program described in the Official Notice, call 1-800-386-2070.**

**14. If you would like to receive information concerning reimbursement benefits for all or part of the cost of certain privately-obtained Echocardiograms, call 1-800-386-2070.**

**15. State whether you elect to receive cash benefits or medical services<sup>3</sup> if you qualify for this benefit. Such benefits or services will only become available to you if the AHP Settlement Trust determines that you are eligible. To seek this benefit, you must complete, sign and mail to the AHP Settlement Trust this BLUE FORM postmarked no later than May 3, 2003. You may select only one option.**

I elect to receive \$6,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ 61 days or more, and I am diagnosed as “FDA Positive” on or before January 3, 2003, or \$3,000 in cash if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as “FDA Positive” on or before January 3, 2003.

**OR**

I elect to receive \$10,000 in heart valve-related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ 61 days or more, and I am diagnosed as “FDA Positive” on or before January 3, 2003, or \$5,000 in heart valve related medical services if the AHP Settlement Trust determines that I took the diet drugs Pondimin® and/or Redux™ for 60 days or less, and I am diagnosed as “FDA Positive” on or before January 3, 2003.

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

- Yes
- No

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

<sup>3</sup> The medical services shall be limited to the care of Valvular Heart Disease. The Trustees may include the following services, when performed, supervised, or prescribed by a physician specializing in internal medicine, cardiology or cardiothoracic surgery: comprehensive physical examinations, chest x-rays, electrocardiograms, standard laboratory testing, medically-appropriate Echocardiograms, and/or medically-supervised nutritional counseling and/or any accepted technology or techniques for the management of valvular heart disease.





17. **Confidentiality.** By signing below, I 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.

18. **CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE.** In consideration of the obligations of American Home Products Corporation (“AHP”) under the Nationwide Class Action Settlement Agreement with American Home Products Corporation (“Settlement Agreement”) 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 the undersigned claims as a representative of the person who used Pondimin® and/or Redux™, whether as heir, beneficiary, agent, estate, executor, administrator, personal representative, successor, assignee, guardian, or otherwise, and in that capacity, or, if applicable, the undersigned as a person who has a Derivative Claim under the Settlement Agreement, and in that capacity, 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), asserted against AHP or any Released Party. The Settlement Agreement, including, without limitation its benefit and its release provisions, and the definitions of the terms “Settled Claims” and “Released Parties,” is incorporated by reference as if fully set out at length. I further agree to the provisions of the Settlement Agreement concerning “Judgment Reduction for Claims by Third Parties” which are summarized in the Notice of Settlement. For purposes of this Conditional Release of Settled Claims and Covenant not to Sue, the terms “Settled Claims” and “Released Parties” are defined as set forth in the Settlement Agreement and in the Notice of Settlement. 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 the undersigned does 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.** In the event that the undersigned properly exercises any Intermediate or Back-End Opt-Out rights under the Settlement Agreement, then this conditional release shall be null and void and of no further force and effect except to the extent provided in Section IV.D of the Settlement Agreement. **I, THE UNDERSIGNED, HAVE CAREFULLY READ (OR HAVE HAD READ TO ME) THIS CONDITIONAL RELEASE OF SETTLED CLAIMS AND COVENANT NOT TO SUE. I, THE UNDERSIGNED, UNDERSTAND THE TERMS OF IT, AND AGREE TO BE BOUND BY IT.**

19. **Declaration under Penalty of Perjury.** 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 AHP Settlement Trust is equivalent to filing it with a Court. Each agrees to cooperate with the AHP Settlement Trust and to provide any necessary medical record authorization and releases for the AHP Settlement Trust to gather information needed to substantiate or audit the Claim. Each 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.

\_\_\_\_\_  
 (Signature of Diet Drug Recipient, if living)

Date: | | / | / | | | |  
 (MM/DD/YYYY)

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

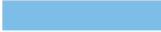
Date: | | / | / | | | |  
 (MM/DD/YYYY)

\_\_\_\_\_  
 (Signature(s) of Claiming Spouse, Parent, Child,  
 Dependent, Other Relative, or “Significant Other,” if any)

Date: | | / | / | | | |  
 (MM/DD/YYYY)

(NOTE—Copy this page if you need room for additional signatures, and include copied and signed pages with this form.)





***REMEMBER: To complete your Claim, you must supply the following to the AHP Settlement Trust:***

1. Written proof of the amount of Pondimin® and/or Redux™ which was dispensed for your use by your drugstore(s), pharmacy(ies), doctor(s), clinic(s) or health care facility(ies).
2. If you are submitting this form as a Representative Claimant, a copy of the order or other document appointing you as the Diet Drug Recipient's legal representative.
3. If you are representing a deceased's estate, a copy of the death certificate, along with a copy of any letters of administration or probate or surrogate certificate.
4. A signed Authorization for the Release of Medical Records included in this form.
5. If you are seeking benefits based on the results of an Echocardiogram(s) that you identified in Question #11, you must supply a copy of each Echocardiogram report and the videotape or disk of each.
6. A GRAY FORM if you are claiming Benefits based upon an Echocardiogram performed after September 30, 1999.  
  
The GRAY FORM must be accompanied by the report of the results of the Echocardiogram and a copy of the Echocardiogram tape or disk.
7. If you claim Matrix Compensation Benefits, you and your doctor must complete the Matrix Compensation Benefits Claim Form—the GREEN FORM—and mail it to:

**AHP Settlement Trust  
P.O. Box 7939  
Philadelphia, PA 19101**

If you change your address, you must promptly notify the AHP Settlement Trust in writing of your new address.

For assistance call 1-800-386-2070, or access the AHP Settlement Trust's website at <http://www.settlementdietdrugs.com>.



  
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS  
AND OTHER HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information and medical records as described below. I understand that this authorization is voluntary. I understand that because the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, but it will be subject to the confidentiality provisions of the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

**Information Authorized for Release:** All prescribing or dispensing physician medical records (including information identifying the undersigned Diet Drug Recipient or patient, the diet drug name, the date(s) prescribed, the dosage and duration the drug was dispensed), echocardiograph recordings and reports (including written reports and echocardiograph videotapes and disks), prescription dispensing records from a pharmacy or other entity (including the drug name, quantity, frequency, dosage, and number of refills, prescribing physician's name, original fill date and each subsequent refill date), and billing records and/or payment records that relate to the Echocardiogram(s) and/or the dispensation of the diet drugs.

I authorize the release of the above records/recordings to the AHP Settlement Trust. The AHP Settlement Trust will pay reasonable charges made by you in accordance with limitations imposed on the Trust by Pretrial Order 1665 – Establishing a Limit on Fees for Retrieval and Copying of Medical Records, to supply copies of such furnished records/or disks.

Patient/Diet Drug Recipient:

\_\_\_\_\_ (First Name)                      \_\_\_\_\_ (Middle Initial)                      \_\_\_\_\_ (Last Name)

Date of birth and Social Security Number of Patient/Diet Drug Recipient:

\_\_\_\_/\_\_\_\_/\_\_\_\_ (Birth Date MM/DD/YYYY)                      \_\_\_\_\_ (Social Security Number)

Persons/Organizations Providing the Information: Any organization maintaining records described above that are necessary to adjudicate the relevant Claim filed under the Nationwide Class Action Settlement Agreement with American Home Products Corporation.

**Mail the above records to:**

AHP Settlement Trust  
P.O. Box 7939  
Philadelphia, PA 19101

I understand that this authorization will expire three (3) years from the date I sign this document as indicated below. In addition, I understand that I may revoke this authorization at any time by notifying the AHP Settlement Trust and the providing organization in writing, but if I do revoke this authorization it will not have any effect on any actions any providing organization took before it received the revocation. Copies of this authorization shall be honored as originals. Also, this authorization does not authorize the disclosure of any information other than the items referenced above.

\_\_\_\_\_  
Signature of Patient/Diet Drug Recipient or Authorized Representative                      \_\_\_\_\_ (Date MM/DD/YYYY)

(If applicable) Printed Name of Authorized Representative: \_\_\_\_\_

(If applicable) Relationship of Representative to Patient/Diet Drug Recipient: \_\_\_\_\_





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# Diet Drug Settlement With American Home Products Corporation

## Declaration of Prescribing Physician or Dispensing Pharmacy

Use this form **ONLY IF** your pharmacy/prescription record(s) are unobtainable as described in Question #10 on pages 4 and 5 of this form. 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™. Make copies of this form as needed.

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

(First Name)	(Middle Initial)	(Last 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 and submitting it to the AHP Settlement Trust 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.

(Signature)	(Date MM/DD/YYYY)
(Printed Name)	



**SUMMARY OF DEADLINES FOR MAILING THE BLUE FORM**

	WHAT YOU WANT TO DO	OTHER FORMS YOU MUST MAIL WITH THE BLUE FORM FOR THIS CHOICE	POSTMARK DEADLINE TO MAIL FORMS
SEEK FUND A MEDICAL MONITORING BENEFITS	Free Echocardiogram in the AHP Settlement Trust's Screening Program	None	August 1, 2002
	Free Echocardiogram in the Compassionate and Humanitarian Program	BROWN FORM	August 1, 2002
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (for those benefits not dependent on whether the Trust has sufficient funds)	WHITE FORM and GRAY FORM	Mail BLUE and WHITE FORMs by May 3, 2003. Mail GRAY FORM as soon as possible after Echo.
	Reimbursement for Echocardiogram received outside the AHP Settlement Trust's Screening Program (if the Trust has sufficient funds)	WHITE FORM	August 1, 2002
	Cash or Additional Medical Services	GRAY FORM (if Echo after 9/30/99)	Mail BLUE FORM by May 3, 2003
	Refund of Prescription Costs	None	August 1, 2002
SEEK FUND B MATRIX BENEFITS	Compensation for Matrix-Level Conditions You Have Now	GREEN FORM	Mail BLUE FORM by May 3, 2003. Mail GREEN FORM by December 31, 2015.
	Preserve the Right to Seek Matrix-Level Benefits in the Future	GRAY FORM and GREEN FORM	Mail BLUE FORM by May 3, 2003. Mail GRAY FORM as soon as possible after Echo. Mail GREEN FORM by December 31, 2015.
SEEK TO OPT OUT OF SETTLEMENT	<p align="center"><b>Back-End Opt-Out</b></p> <p>(Must be diagnosed as FDA Positive or having mild mitral regurgitation by January 3, 2003, must reach a Matrix-Level condition for the first time after September 30, 1999, and must meet other requirements)</p>	ORANGE FORM #3	Mail BLUE Form by May 3, 2003. File ORANGE FORM #3 no later than May 3, 2003, or 120 days after the Diet Drug Recipient knew or should have known of the Matrix-Level condition.

