

ORANGE FORM #2

INTERMEDIATE OPT-OUT FORM Diet Drug Settlement With Wyeth

If you qualify for an Intermediate Opt-Out right under Section IV.D.3 of the Nationwide Settlement Agreement and you wish to exercise that right, you must use this ORANGE FORM #2. You must be a Diet Drug Recipient or a Representative Claimant of a Diet Drug Recipient to exercise an Intermediate Opt-Out.

To register your intent to opt out as an Intermediate Opt-Out, complete fully all sections of this form, sign it, date it, and mail the original to the AHP Settlement Trust and a copy to Wyeth at the addresses shown on page 2. *To be timely, your mailings must be postmarked no later than May 3, 2003.*

The Diet Drug Recipient or authorized Representative Claimant who wishes to opt out must sign this form personally. Attorneys may not sign this form on behalf of a client, unless the attorney qualifies as a Representative Claimant under Question 2 of this form.

1. State the name, address, Social Security Number, date of birth, telephone number, and Claim Number assigned by the AHP Settlement Trust, if any, for the relevant Diet Drug Recipient upon whom this opt-out is based.

| | | |
|------------------------------------|------------------|------------------------------------|
| _____ | _____ | _____ |
| (First Name) | (Middle Initial) | (Last Name) |
| _____ | | |
| (Street Address) | | |
| _____ | _____ | _____ |
| (City) | (State) | (Zip Code) |
| _____ | 18300 - _____ | _____/_____/_____ |
| (Social Security Number) | (Claim Number) | (Date of Birth MM/DD/YYYY) |
| (_____) _____ | | (_____) _____ |
| (Daytime Area Code & Phone Number) | | (Evening Area Code & Phone Number) |

2. If you are completing this form as the Representative Claimant (i.e., estate, administrator, or other legal representative, heir, or beneficiary of a Diet Drug Recipient) complete all of the following. You also must attach a copy of the order or document authorizing you to act as the Representative Claimant of the Diet Drug Recipient identified above.

| | | |
|--|------------------|------------------------------------|
| _____ | _____ | _____ |
| (First Name) | (Middle Initial) | (Last Name) |
| _____ | | |
| (Street Address) | | |
| _____ | _____ | _____ |
| (City) | (State) | (Zip Code) |
| _____ | 18300 - _____ | _____/_____/_____ |
| (Social Security Number) | (Claim Number) | (Date of Birth MM/DD/YYYY) |
| (_____) _____ | | (_____) _____ |
| (Daytime Area Code & Phone Number) | | (Evening Area Code & Phone Number) |
| _____ | | |
| (Your relationship to the Diet Drug Recipient) | | |





3. If you have a lawyer who represents you in connection with the Diet Drug Litigation, list his/her name, office address, telephone number, fax number, and E-mail address, if any. If you do not have a lawyer, leave Question #3 blank.

 (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)

4. **CERTIFICATION: I have had an opportunity to read the Official Notice authorized by the Court in connection with the Final Judicial Approval of the Nationwide Class Action Settlement with American Home Products Corporation and to consult with physicians and attorneys concerning the terms and conditions of the Class Action Settlement. I HEREBY CERTIFY, SUBJECT TO PENALTIES OF PERJURY, THAT TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF, MY CIRCUMSTANCES QUALIFY ME TO EXERCISE AN INTERMEDIATE OPT-OUT RIGHT UNDER THE SETTLEMENT AGREEMENT. I HEREBY KNOWINGLY AND PERMANENTLY RELINQUISH, WAIVE AND GIVE UP ALL OF THE RIGHTS, WHICH I WOULD OTHERWISE HAVE HAD AS A CLASS MEMBER UNDER THE SETTLEMENT AGREEMENT WITH AMERICAN HOME PRODUCTS CORPORATION, AND I AFFIRMATIVELY AND FOREVER OPT OUT OF THE CLASS WITH FULL KNOWLEDGE OF THE LEGAL, FACTUAL AND MEDICAL CONSEQUENCES OF MY ACTIONS.**

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. I declare under penalty of perjury that the information provided in this form is true and correct to the best of my knowledge, information and belief.

 (Signature of Diet Drug Recipient or Representative Claimant)

/ /
 (Date: MM/DD/YYYY)

You must mail the original of this form to the AHP Settlement Trust and a copy of this form to Wyeth at the following addresses:

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

**Wyeth
 c/o Orran L. Brown
 BrownGreer PLC
 115 South 15th Street
 Suite 400
 Richmond, VA 23219-4209**

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

