SWC Asbestos Personal Injury Trust[1]

Claim Form for Unliquidated Asbestos Personal Injury Claims

General Instructions for filing this Claim Form:

This Claim Form should be completed by Holders of Asbestos Claims seeking to liquidate their claim against the Debtors[2] under the SWC Asbestos Personal Injury Trust (the "**Asbestos Trust**") pursuant to the processes set forth in the SWC Asbestos Personal Injury Trust Distribution Procedures (as may be amended from time to time, the "**TDP**").

This Claim Form must be completed as thoroughly as possible to ensure prompt resolution of claims. Submitting an incomplete Claim Form may result in delays in processing and/or the Asbestos Trust not being able to timely assess the Scheduled Values of Allowed Asbestos Claims and pay Allowed Asbestos Claims in accordance with the TDP. Please type or print neatly within the spaces provided. If additional space is required to provide all relevant information, please attach additional copies of the relevant section of this form.

Section 1: Claim Information
Check the box next to the review type which best suits the Injured Party's[3] situation: ☐ Expedited ☐ Individual ☐ Secondary Exposure ☐ Foreign
Check the box corresponding to the exposure source that forms the basis of the claim (check all that apply): ☐ Yuba ☐ Danly ☐ Wabash
Law Firm Claim Matter Number: _____

Section 2: Claimant Information				
Last Name	First Name	Middle Name		Suffix
Social Security Number, Tax ID, or International ID Number	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Date of Death (mm/dd/yyyy) (if deceased)	Was death asbestos related? ☐ Yes ☐ No
Mailing Address (if not represented by counsel)				
City	State	Zip Code	Country	Daytime Telephone

[1] Capitalized terms used herein and not otherwise defined shall have the meanings assigned to them in the TDP.

[2] As used herein, "Debtor(s)" shall mean individually or collectively SWC Industries LLC (8214); SWC Limited Partnership (3203); SWC Holdings, LLC (0051); Yuba Heat Transfer, LLC (0587); SWC Aluminum Properties, L.L.C. (0299); SWC Tool Properties, LLC (0106); SencorpWhite, Inc. (2755); SWC CeraTek LLC (2504); Accu-Seal SencorpWhite, Inc. (1845); IITI Acquisition LLC (9038); SWC White Systems LLC (8135); Intek Integration Technologies, Inc. (3507); Minerva Associates, Inc. (5223). The Debtors' service address is One International Place, Suite 3110, Boston, MA 02110.

[3] "Injured Party" means the person who claims to have sustained injury or harm from the presence of or exposure to the products or operations of one or more of the Debtors or any predecessor of one or more of the debtors (or any Entity for whose products or operations the debtors have or allegedly have legal responsibility).

Section 3: Law Firm / Attorney Information

If represented by counsel, please provide the following information:

Law Firm Name		EIN
Mailing Address		
City	State	Zip Code
Attorney Last Name	Attorney First Name	Direct Telephone
Para/Admin Last Name	Para/Admin First Name	Direct Telephone
E-mail	Facsimile	

Section 4: Personal Representative (*if applicable*)

Last Name	First Name	Middle Name	Suffix
Social Security Number, Tax ID, or International ID Number (optional)	Capacity of Personal Representative *(i.e., Administrator, Executor, Guardian, etc.)*		
Mailing Address			

City	State	Zip Code	Country	Daytime Telephone

Certificate of Official Capacity or other estate documentation must be enclosed if applicable pursuant to state law.

If no Certificate of Official Capacity or other estate documentation is available, attorney must provide official representative certification by signing below:

Attorney certifies that this claim is filed on behalf of the Official Representative acting for the Injured Party and that the Official Representative has official capacity to file this claim based on the operation of law.

Signature of Attorney: _____

Printed Name: _____

Section 5: Asbestos Litigation History

If an asbestos-related lawsuit has ever been filed on behalf of the Injured Party, please provide the following information.

Filing Date (mm/dd/yyyy)	State	Court	Docket Number

Was SWC, Yuba, Danly, and/or Wabash Named as defendant?	Has the Injured Party ever received settlement monies related to this lawsuit from SWC, Yuba, Danly, and/or Wabash and/or their insurers?
☐ Yes ☐ No	☐ Yes ☐ No If "Yes," amount: $ _____

Jurisdiction Selection

If no lawsuit has ever been filed against SWC, Yuba, Danly, and/or Wabash on behalf of the Injured Party, indicate the state elected as the Claimant's Jurisdiction: _____

Jurisdiction elected is (please check one of the following):

☐ The state in which the Injured Party resided at the time of diagnosis.

☐ The state in which the Injured Party resided when this claim was filed with the Trust.

☐ A state in which the Injured Party was allegedly exposed to an asbestos-containing product manufactured, used or distributed by SWC, Yuba, Danly, and/or Wabash.

Has a claim on behalf of the Injured Party ever been submitted to SWC, Yuba, Danly, and/or Wabash pursuant to an administrative settlement agreement?

☐ Yes ☐ No

If Yes, provide the date of such submission (mm/dd/yyyy): _____

Was the Injured Party or claimant a party to a tolling agreement with SWC, Yuba, Danly, and/or Wabash?

☐ Yes ☐ No

If Yes, provide the beginning and ending dates, if any, of the tolling and attach documentation of the agreement.

Beginning date (mm/dd/yyyy): _____ Ending date (mm/dd/yyyy): _____

Section 6: Asbestos-Related Injuries (Disease Levels 1, 2, 3, and 4)

Check the box next to the highest disease level the Injured Party is claiming.

Disease Level			
Disease Level 1 (Asbestosis)	Other Cancer (Disease Level 2)	Lung Cancer (Disease Level 3)	Mesothelioma/ Asbestosis Death (Disease Level 4)
☐ Disease Level 1-A (Non-Disabled Asbestosis) ☐ Disease Level 1-B (Disabled Asbestosis)	☐ Colorectal ☐ Laryngeal ☐ Esophageal ☐ Pharyngeal ☐ Stomach ☐ Other (Please Specify): _____	☐ Disease Level 3-A (Lung Cancer 1) ☐ Disease Level 3-B (Lung Cancer 2)	☐ Mesothelioma ☐ Asbestosis Death
Date of Diagnosis (mm/dd/yyyy):			
☐ If the Injured Party has filed a timely proof of claim for Disease Level 1-A and elects the Discounted Cash Payment, please check the box.			
☐ If the Injured Party has filed a timely proof of claim for Disease Level 1-B and elects the Scheduled Value, please check the box.			
☐ If the Injured Party has filed a timely proof of claim for Disease Levels 2, 3, or 4 and elects to pursue a distribution of the Scheduled Value for his/her claim, please check this box.			
☐ If the Injured Party has filed a timely proof of claim for Disease Level 2, 3, or 4 and elects to have the Asbestos Trustee individually review his/her claim, please check this box and provide any additional information or supporting documentation you wish for the Asbestos Trustee to take into consideration in evaluating the claim, including dependents and economic loss. See TDP, Sec. 2.2(e).			

Section 7: Occupational Exposure to Asbestos-Containing Machinery or Premise Liability and Significant Occupational Exposure

Provide information below for each location at which the Injured Party alleges occupational exposure to asbestos-containing equipment and/or conduct for which the Debtors have legal responsibility or premises liability. Attach additional copies of this page if more space is required. Evidence of exposure may be established by documentation including, but not limited to, the following:

- An affidavit or sworn statement of the Injured Party; however, execution of this Claim Form by the Injured Party may serve as the sworn statement of the Injured Party
- An affidavit or sworn statement of a co-worker or a family member (if the Asbestos Claimant is deceased)
- An affidavit or sworn statement of a family member in the case of a deceased Injured Party
- Invoices, employment, construction or similar records
- Interrogatory answers, sworn work history, or deposition testimony by the Injured Party, a co-worker

Note: If the claimant alleges an asbestos-related disease resulting solely or in part from exposure to an occupationally exposed person, such as a family member, Section 7 must be completed for the occupationally exposed person. If the Injured Party also had direct, occupational exposure to asbestos, Section 7 must also be completed for that exposure.

Part 1: Occupational Exposure to an Asbestos-Containing Equipment

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation

☐ By checking this box, the Injured Party certifies exposure to asbestos-containing equipment for which the Debtors have legal responsibility.

If you would like to provide more information, please use the following space:

For Medicare reporting purposes, was the Injured Party exposed on or after December 5, 1980, to asbestos-containing products and/or conduct for which the Injured Party alleges the Debtors have legal responsibility?

☐ Yes ☐ No

Industry in Which Exposure Occurred:

Description and Site or Customer Location of Exposure:	City	State	Country

Name of Injured Party's Employer at time of asbestos exposure:

If the claimant alleges secondary exposure at this site, please enter the name of the occupationally exposed individual to whom the Injured Party was exposed:

OEP Last Name	OEP First Name	OEP Middle Name	OEP Suffix

OEP Social Security Number, Tax ID, or International ID Number (optional)	Date exposure to OEP began (mm/dd/yyyy)	Date exposure to OEP ended (mm/dd/yyyy)

Relationship to OEP	OEP Date of Death (mm/dd/yyyy) (if applicable)
Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the Trust is alleged to be legally responsible.	

Part 2: Premise Liability

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Occupation
For Medicare reporting purposes, was the Injured Party exposed on or after December 5, 1980, to asbestos-containing products and/or conduct for which the Injured Party alleges the Debtors have legal responsibility? ☐ Yes ☐ No		

Site of Exposure (plant or site name)	City	State	Country
Industry in which exposure occurred:			
Names of all asbestos-containing products to which the Injured Party was exposed and for which the claimant alleges the Debtors have legal responsibility:			
Description of Exposure:			
If the claimant alleges secondary exposure at this site, please enter the name of the occupationally exposed individual to whom the Injured Party was exposed:			

OEP Last Name	OEP First Name	OEP Middle Name	OEP Suffix

OEP Social Security Number, Tax ID, or International ID Number (optional)	Date exposure to OEP began (MM/DD/YYYY)	Date exposure to OEP ended (MM/DD/YYYY)

Relationship to OEP	OEP Date of Death (mm/dd/yyyy) (if applicable)

Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the Trust is alleged to be legally responsible.

Part 3:

"**Significant Occupational Exposure**" means employment for a cumulative period of at least five (5) years in an industry and an occupation in which the claimant

☐ (a) handled raw asbestos fibers on a regular basis;

☐ (b) fabricated asbestos-containing products so that the claimant in the fabrication process was exposed on a regular basis to raw asbestos fibers;

☐ (c) altered, repaired or otherwise worked with an asbestos-containing product such that the claimant was exposed on a regular basis to asbestos fibers; or

☐ (d) was employed in an industry and occupation such that the claimant worked on a regular basis in close proximity to workers engaged in the activities described in (a), (b) and/or (c).

Section 8: Smoking History (required only for Individual Review Claims for Lung Cancer)			
Cigarettes ☐ Yes ☐ No	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Cigarettes Per day
Cigars ☐ Yes ☐ No	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Cigars Per day
Pipes ☐ Yes ☐ No	Start Date (mm/dd/yyyy)	Quit Date (mm/dd/yyyy)	Pipes Per day

Section 9: Dependents (not required for Expedited Review)

List all individuals who are financially dependent upon the Injured Party. If more space is needed, attach additional copies of this page.

Dependent 1

Last Name	First Name	Middle Name	Suffix
Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	Relationship to Injured Party	

Dependent 2

Last Name	First Name	Middle Name	Suffix
Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	Relationship to Injured Party	

Dependent 2

Last Name	First Name	Middle Name	Suffix
Date of Birth (mm/dd/yyyy)	Financially Dependent? ☐ Yes ☐ No	Relationship to Injured Party	

Section 10: Employment / Earnings (required only for Individualized Review for lost wages due to an asbestos-related illness)

If economic losses are being claimed as a result of an asbestos-related injury, please enclose an economic loss report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

Current Employment Status of the Injured Party:

☐ Full-time ☐ Fully Disabled

☐ Part-time ☐ Partially Disabled

☐ Retired ☐ N/A (Deceased)

☐ Unemployed

Amount of last annual wages:	Date of last wages received (mm/dd/yyyy)
$ _____	

Section 11: Certification and Signature

This claim form must be signed by an attorney or by the claimant if not represented by an attorney.

If signed by the claimant, I (the claimant) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge, under penalty of perjury, the information submitted is accurate and complete.

If signed by the claimant's counsel, I (counsel to the claimant) certify that the information and materials with respect to this claim are being submitted pursuant to and subject to the provisions of Rule 11 of the Federal Rules of Civil Procedure.

Signature of Claimant or Claimant's Attorney	Date (mm/dd/yyyy)
Print Name Here	
Signatory's Relationship to Injured Party	

To file by mail, send this completed form and all supporting documentation to:

SWC Asbestos Personal Injury Trust
c/o Verus Claims Services, LLC
3967 Princeton Pike
Princeton, NJ 08540

Section 12: Checklist of Supporting Documentation

Please attach the following supporting documentation to the completed claim form.

For all claimants as required by the TDP:

- ☐ Filing fee required for injury or source (e.g. foreign) being claimed
- ☐ Medical records supporting the diagnosis of the claimed Disease Level
- ☐ Proof of Exposure, if applicable

Other supporting documentation, as applicable:

- ☐ Certificate of Official Capacity or other estate documentation must be enclosed if applicable pursuant to state law. If such documentation is not available, the Law Firm/Attorney's Representatives Affirming Official Representative's Authority must be provided.
- ☐ Documents and information referenced in Section 7 (if applicable)

For deceased Injured Parties:

- ☐ Death certificate.