MUST BE POSTMARKED NO LATER THAN NOVEMBER 19, 2010

BMS AWP SETTLEMENT CLASS 3 CLAIM FORM

OFFICIAL USE ONLY

FOR PAYMENTS MADE OUTSIDE OF MEDICARE PART B

How to Apply for a Payment from the Proposed Settlement

If you would like to submit a claim in the Settlement, complete this form and mail it to the address below.

YOUR CLAIM MUST BE RECEIVED OR POSTMARKED NO LATER THAN NOVEMBER 19, 2010.

Your claim should be mailed to:

BMS AWP CLASS 3 Settlement Administrator
P.O. Box 2366
Faribault, MN 55021-9066

Section A: Claimant Identification

Please provide us with the following information related to the individual who was prescribed one or more of the BMS Drugs. This person is referred to as the "Claimant."

Claimant's First Name:

Claimant's Last Name:

Address:

City:

State:

Zip Code:

Daytime Telephone Number:

Section B: Claimant Representative Information

If you are the Claimant, do not complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the Claimant listed above. Please provide YOUR name, relationship to the Claimant, and YOUR contact information in the spaces provided below.

Contact Name:

Address:

City:

State:

Zip Code:

Daytime Telephone Number:

Section C: Should I file a Claim Form?

Please answer the following questions in order to determine if the Claimant is eligible for cash from the Proposed Settlement:

1. Were you, or the Claimant that you are filing on behalf of, prescribed any of the BMS Drugs listed in the Notice during the period from January 1, 1991 through December 31, 2004? ☐**Yes** ☐**No**

2. Did you, or the Claimant that you are filing on behalf of, pay a percentage of the cost of the drug(s) or full cash payments for the drug(s)? ☐**Yes** ☐**No**

Note: If you paid a flat co-payment (i.e., your out-of-pocket expense was always the same for every drug, like a $10 or $25 co-pay) you did not pay a percentage of the cost.

If you answered ***No*** to either of the questions above, you are not eligible to receive any benefits from this Proposed Settlement. You may disregard this Notice and Claim Form. If you answered ***Yes*** to both of the questions above, you should fill out Section D, Section E and Section G below.

Section D: Choose a Refund Option – You Have Two Options

Please check ***only one*** of the boxes below in order to choose your refund option:

☐ **Option 1:** I choose the **EASY REFUND** option. I understand that I will receive a payment of up to $35.00 from the Settlement and that I will not be required to provide additional documentation unless requested by the Claims Administrator **AND** you must sign and date the Claim Form in Section G on page 4 and mail it to the Claims Administrator at the address indicated on page 4.

☐ **Option 2:** I choose the **FULL REFUND** option. I understand that in order to receive a full refund I must provide one form of proof of a percentage co-payment or full cash payment for each separate BMS Drug listed on the chart in Section E for which I am seeking a refund. The list of acceptable forms of proof are listed below in Section F under "Option 2: FULL REFUND." Please include all proof(s) of payment when submitting this Claim Form.

Section E: Drug Purchase Information – Fill out ONLY if you chose Option 2 – FULL REFUND

Instructions for Completing the Out-of-Pocket Expenditures Chart

In the Out-of-Pocket Expenditures Chart below, please provide the total amount paid (not monthly) by the Claimant, or the amount the Claimant is obligated to pay, for each of the drugs listed.

- Print clearly
- Do not include flat co-payments in the total amounts paid
- Enter the full amount paid, not a monthly amount

Out-of-Pocket Expenditures on BMS Drugs

Drug Name	Total Amount Paid From January 1, 1991 through December 31, 2004
Blenoxane®	$
Cytoxan®	$
Etopophos®	$
Paraplatin®	$
Rubex®	$
Taxol®	$
Vepesid®	

Section F: Proof of Payment – Provide ONLY if you chose Option 2 – FULL REFUND

If you chose Option 2, you must provide proof that you made a percentage co-payment for each of the Class Drugs you are claiming in the chart in Section E above. You only need to provide one form of proof for each of the drugs.

Any one of the following are acceptable as proof of a percentage co-payment for one of the Class Drugs:

(1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or

(2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part or all of the cost of one of the drugs (other than a flat co-payment) at least once; or

(3) Billing records from a doctor or other health care provider showing that you made or are obligated to make part or all of the cost of one of the BMS Drugs (other than a flat co-payment); or

(4) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the BMS Drugs; or

(5) Any combination of (1)-(4) above.

Section G: Sworn Statement Regarding Payments Made

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I paid a percentage co-pay or full cash payment for one or more of the BMS Drugs as indicated in this Claim Form at some time during the period from January 1, 1991 through December 31, 2004. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above[1].

Signature

Print Name

Date

Mail all pages of this Claim Form along with proof(s) of payment, if any, to the following address:

BMS AWP Class 3 Settlement Administrator
P.O. Box 2366
Faribault, MN 55021-9066

Toll-Free Telephone: 1-877-690-7097

[1] Please note that your signature on this Claim Form indicates that you declare, under penalty of perjury, that you (or someone on whose behalf you are acting) made a percentage co-payment or full cash payment for one or more of the BMS Drugs at some time during January 1, 1991 through December 31, 2004. As a result, providing false information on this Claim Form could constitute perjury.