IN RE: NEW ENGLAND COMPOUNDING PHARMACY INC.

Confidential Personal Injury or Wrongful Death Claim Information Form (the "PITWD Addendum")

CLAIMANT NAME: _____

IMPORTANT - DO NOT FILE THIS DOCUMENT WITH THE COURT – SEE SPECIAL INSTRUCTIONS TITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIM PROCEDURES."

Please provide the following information **TO THE BEST OF YOUR ABILITY** for each individual making a claim about exposure to New England Compounding Pharmacy, Inc. d/b/a New England Compounding Center ("NECC") products. More information, including a list of NECC products, is available at http://www.cdc.gov/hai/outbreaks/meningitis-facilities-map.html and http://www.donlinrecano.com/necp **SEE SPECIAL INSTRUCTIONS TITLED "NOTICE OF DEADLINES FOR FILING CLAIMS AND CLAIMS PROCEDURES."** You will need to submit this Form and your proof of claim by **January 15, 2014 at 4:00 p.m. (prevailing Eastern Time).**

- The "You" used in this Form means the person who was exposed to NECC products.
- "Product" means any medication or solution compounded by NECC.
- In filling out any section or sub-section of this Form, please submit additional sheets as necessary to provide complete information.
- If, at a later date, you learn that any of your responses are incomplete or incorrect, please submit that information as soon as you become aware of it. In addition, supplemental information and documentation will likely be requested after you submit this initial Form.

In completing this Form, you are considered to have done so under oath. You must provide information that is true and correct to the best of your knowledge, information, and belief. If information is not known, remembered, or available indicate that in the appropriate location.

After reviewing your Form, additional information and documentation will likely be requested from you. Please contact the Chapter 11 Trustee immediately if you need to correct any of your answers or can provide more complete information. You may and should consult with your attorney regarding completing this Form. **IF YOU ARE NOT REPRESENTED BY COUNSEL OR OTHERWISE ARE UNABLE TO FURNISH ANY OF THE INFORMATION REQUESTED, PLEASE PROVIDE AS MUCH OF THE INFORMATION AS YOU CAN.**

Please Do Not Contact The Court With Any Questions Or For Additional Information.

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I. CASE INFORMATION

1. Name of person on whose behalf a claim is being made (first, middle name or initial, last), including maiden or other names used: _____

   a. Were you (or the person identified above) administered the steroid methylprednisolone acetate?

      [ ] Yes [ ] No [ ] Do Not Know

2. Name of person signing this form, if different than above: _____

   a. Relationship of signer to party on behalf of whom claim is being made: (such as spouse, parent, family member, adult child, guardian): _____

   b. If you are filling this out on behalf of an individual who is deceased, please state the date of death, and attach a copy of a death certificate, if you have it.

3. Please check the injuries you sustained as a result of exposure to the NECC Product(s):

   a. [ ] Death

   b. [ ] Fungal Meningitis

   c. [ ] Epidural Abscess

   d. [ ] Stroke or stroke like symptoms (Cerebral Vascular Accident)

   e. [ ] Lumbar Puncture (Spinal Tap), No Subsequent Treatment

   f. [ ] Lumbar Puncture (Spinal Tap), Subsequent Treatment

   g. [ ] Infection of any kind, describe if known: _____

   h. [ ] Injection only, no symptoms or treatment

   i. [ ] Other (describe): _____

   (Attach additional sheets if necessary to describe.)

4. Was any lawsuit or civil action started based on your exposure to an NECC Product, including any claiming wrongful death or claiming on behalf of an estate or survivors?

   [ ] Yes [ ] No

If yes, please state:

a. Case caption: _____

b. Court and Docket number: _____

c. Name, address, telephone number, fax number and e-mail address of attorney representing you, if you know:

Attorney Name: _____

Firm: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

THE REST OF THIS FORM REQUESTS INFORMATION ABOUT THE PERSON EXPOSED TO THE PRODUCT

II. Personal Information

5. Current address and date(s) when you lived at this address:

_____

6. Social Security Number (***LAST 4 DIGITS*** **ONLY**): XXX-XX-_____

7. Date of birth:_____

8. Are you married? [ ] Yes [ ] No

III. Medical Information

9. Date(s) you were administered or used an NECC Product:

_____

10. Hospital / clinic / physician's office where you were administered the Product:

(Name / Full Address) _____

_____

a. Name of physician who administered the Product:_____

11. What was the medical condition for which you were treated with the NECC Product (for example, osteoarthritis, back injury, etc.)?

_____

12. Have you been tested for meningitis or fungal infection? [ ] Yes [ ] No

a. If yes, provide:

1. Where? Name and full address of the facility

_____

2. When? Date(s) of test(s) (mm/dd/yyyy):

_____

3. Have you had a lumbar puncture/spinal tap since your exposure to an NECC Product? [ ] Yes [ ] No

13. Are any of the previously described physical conditions, referred to in paragraph 3, still affecting you?

[ ] Yes [ ] No

a. If Yes, please list and describe.

_____

_____

IV. EMPLOYMENT INFORMATION

14. Are you making a claim for past lost wages or future lost earning capacity or other economic loss, other than for medical bills?

[ ] Yes [ ] No

15. Have you filed a disability claim with any private insurance company or local/state/federal agency?

[ ] Yes [ ] No

If yes, when? _____

16. Did you have medical insurance for treatment rendered? [ ] Yes [ ] No

a. If yes, please provide the following information for each insurance company. If more than one, please provide information for all:
Name of Health Insurance: _____

Policy No.: _____

Name of Subscriber: _____

b. If you have Medicare or Medicaid coverage, please state your ID number:

c. Has any insurance company asserted a lien on your recovery? [ ] Yes [ ] No
If yes, please provide the name of the lienholder: _____

Signature[1]: _____

Print or Type Name: _____

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[1] Please note that your signature is deemed to be under oath.