

**BABCOCK & WILCOX COMPANY ASBESTOS PERSONAL INJURY SETTLEMENT TRUST
PROOF OF CLAIM FORM**

Part 2: Diagnosed Asbestos-related Injuries

1. Place an X next to the highest level (most serious) asbestos-related Disease Category that has been diagnosed for the injured party and for which medical documentation is attached to this claim form. See instructions for a list of specific medical criteria and records that must be enclosed for each Disease Category. **(Check only the most serious)**

<u>Level</u>	<u>Scheduled Disease</u>
<input type="checkbox"/> VIII	Mesothelioma
<input type="checkbox"/> VII	Lung Cancer I
<input type="checkbox"/> VI	Lung Cancer 2 (Individual Review Only)
<input type="checkbox"/> V	Other Cancer (Please specify: _____)
<input type="checkbox"/> IV	Severe Asbestosis (ILO of 2/1 or greater, or asbestosis determined by pathology plus (a) TLC less than 65% or (b) FVC less than 65% plus FEV1/FVC ratio greater than 65%)
<input type="checkbox"/> III	Asbestosis/Pleural Disease (Bilateral Asbestos-Related Non-Malignant Disease plus (a) TLC less than 80% or (b) FVC less than 80% and FEV1/FVC ratio greater than or equal to 65%)
<input type="checkbox"/> II	Asbestosis/Pleural Disease (Bilateral Asbestos-Related Non-Malignant Disease)
<input type="checkbox"/> I	Other Asbestos Disease (Cash Payment Discount, not subject to the Payment Percentage)

2. Date of Diagnosis: _____ / _____ / _____
(month) (day) (year)

The claims must meet the relevant medical criteria and be supported by appropriate medical documentation as defined in the Asbestos Personal Injury Trust Distribution Procedures. The presumptive medical criteria for the Disease Categories set forth above are included in the instructions.

For claims filed against B&W or any other asbestos defendant in the tort system prior to the Petition Date, please check this box if you have filed a physical examination report with another asbestos-related personal injury settlement trust. (see sections 5.7(a)1(a) and 5.7(a)1(c) of the TDP)

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Part 3: B&W or Other Asbestos Exposure and Significant Occupational Exposure

Proof of Babcock & Wilcox (B&W) exposure and proof of Significant Occupational Exposure to all asbestos-related products are addressed below and must be enclosed as required by Asbestos Personal Injury Trust Distribution Procedures sections 5.3 and 5.7(b). (See instructions) **Please photocopy this section and list separately each company site, industry, and occupation combination upon which you rely to meet the exposure requirements of the TDP.**

Please include detail concerning all asbestos exposure (not just B&W exposures) which you think is sufficient to meet the criteria for approval of the claim at the claimed disease level. List each site, industry and occupation combination separately.

For B&W exposures, a list of approved B&W sites is available on the Trust website (www.bwasbestostrust.com). Please reference this list and enter the Approved B&W Site Code in item #1 below.

If the site you are alleging exposure to B&W products or services is not on the approved B&W site list, provide independent documentation of meaningful and credible evidence of exposure to asbestos-containing products manufactured by B&W or for which B&W is liable. This may be established by documentation including, but not limited to, the following:

- *An affidavit of the injured party (an example is included in the filing instruction)*
- *An affidavit of a co-worker*
- *An affidavit of a family member in the case of a deceased claimant*
- *Invoices*
- *Construction or similar records*
- *Sworn statement, interrogatory answers, sworn work history, or deposition*

1. Site/Plant/Ship where Exposure Occurred:

If the site is on the approved B&W site list, enter the Site Code from Exhibit A (available on website):

Approved B&W Site Code (see Exhibit A): _____

If the site/plant/ship is not on the approved list or is not an exposure to B&W products or services, please complete the following:

Name of Ship/Plant/Site of Exposure: _____

City: _____

State/Province: _____

Country: _____

Name of B&W product(s), if applicable, to which the injured party is alleging exposure:

2. Date Exposure Began: _____ / _____
(month) (year)

Date Exposure Ended: _____ / _____
(month) (year)

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(Part 3, continued)

3. Occupation at time of Exposure (e.g., Boilermaker, Laborer, etc.): _____

4. Industry in which exposure occurred: _____ **(Industry codes listed below)**

If Code 37 - Other, please describe: _____

<u>Industry Codes</u>	
10. Asbestos mining	24. Petrochemical
11. Aerospace/aviation	25. Insulation
12. Asbestos abatement	27. Railroad
13. Automobile/mechanical friction	30. Shipyard-construction/repair
16. Chemical	31. Textile
17. Construction trades	32. Tire/rubber
18. Iron/steel	33. Utilities
19. Longshore	34. Asbestos products manufacturer
20. Maritime	36. Building occupant
21. Military	37. Other
23. Non-asbestos products manufacturing	

5. If your occupation does not appear on the list of Presumptive SOE Occupations Ratings (available at www.bwasbestostrust.com), please advance directly to question 6. If it does appear on the list, indicate circumstances of exposure to asbestos products or activities (check all applicable):

- Claimant handled raw asbestos fibers on a regular basis
- Claimant fabricated asbestos-containing products such that the claimant in the fabrication process was exposed on a regular basis to raw asbestos fibers
- Claimant altered, repaired or otherwise worked with an asbestos-containing product such that the claimant was exposed on a regular basis to asbestos fibers
- Claimant was employed in an industry or occupation such that the claimant worked on a regular basis in close proximity to workers who did one or more of the above three activities
- None of the above

6. If the claimant's occupation **does not** appear on the list of Presumptive SOE Occupations Ratings, or "None of the above" was checked in question 5 above, provide a description of how the claimant was exposed to asbestos.

7. If this exposure is in support of *Exposure to an Occupationally Exposed Person* from Part 4, please enter the name of the occupationally exposed individual:

_____ (Last) _____ (First) _____ (MI)

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Part 4: Exposure to an Occupationally Exposed Person

Note: If a claimant alleges an asbestos-related disease resulting solely or in part from exposure to an occupationally exposed person, such as a family member, the claimant must seek Individual Review of his or her claim pursuant to Sections 5.3(b) and 5.5 of the Trust Distribution Procedures. See Choice of Claim Process box on first page of this claim form.

1. Is the claimant alleging an asbestos-related disease resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)?

Yes _____ No _____

If yes, Part 3 must also be completed for each occupationally exposed person.

2. Date Exposure to other person began: _____ / _____
(month) (year)

3. Date Exposure to other person ended: _____ / _____
(month) (year)

4. Relationship to occupationally exposed individual:

(brother, son, spouse, etc.)

5. Social Security Number of occupationally exposed individual: _____ - _____ - _____

6. Describe how injured party was exposed through the occupationally exposed individual to the B&W product:

Reminder: Part 3 must be completed for the occupationally exposed person. If the injured party also had direct, occupational exposure to asbestos, Part 3 must also be completed for that exposure.

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Part 5: Litigation/Claims History

1. Has an asbestos-related lawsuit ever been filed on behalf of the injured party? Yes ___ No ___
 - a. Was B&W named as a defendant? Yes ___ No ___
 - b. State in which the suit was originally filed: _____
 - c. Name of court in which the suit was originally filed: _____
 - d. Case number: _____
 - e. Date the suit was originally filed: _____ / _____ / _____
(month) (day) (year)
 - f. Have you received money from B&W regarding this suit? Yes ___ No ___

2. If the answer to question 1(a) above is No, in which state/jurisdiction would the claimant have elected to file suit against B&W? _____
(state)

3. Was a tolling agreement for the injured party ever in effect with respect to the claim(s) against B&W?
Yes ___ No ___
 - a. Date the tolling agreement began: _____ / _____ / _____
(month) (day) (year)
 - b. Date the tolling agreement ended: _____ / _____ / _____
(month) (day) (year)

4. Has a claim been filed with B&W pursuant to an administrative settlement agreement?
Yes ___ No ___
 - a. Date the claim was originally filed: _____ / _____ / _____
(month) (day) (year)
 - b. Have you received money from B&W regarding this claim? Yes ___ No ___

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Part 6: Financial Dependents and Beneficiaries

List any other persons who may have rights associated with this claim. Be sure to include the injured party's spouse and/or any other financial dependents who derive (or who derived at the time of diagnosis of the asbestos-related disease claimed) at least one-half of their financial support from the injured party. ***This must be completed for IR claims only.***

If additional space is required, please photocopy this page and insert after current page.

1. Name: _____ (Last) (First) (MI)	2. Date of Birth: ____/____/____ (month) (day) (year)
3. Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Heir <input type="checkbox"/> Other _____	4. Financially Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Name: _____ (Last) (First) (MI)	2. Date of Birth: ____/____/____ (month) (day) (year)
3. Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Heir <input type="checkbox"/> Other _____	4. Financially Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Name: _____ (Last) (First) (MI)	2. Date of Birth: ____/____/____ (month) (day) (year)
3. Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Heir <input type="checkbox"/> Other _____	4. Financially Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No

1. Name: _____ (Last) (First) (MI)	2. Date of Birth: ____/____/____ (month) (day) (year)
3. Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Heir <input type="checkbox"/> Other _____	4. Financially Dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No

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Part 7: Smoking History

For each item, indicate whether the injured party has smoked. Please indicate the dates cigarettes or cigars were used, and the amount per day. Indicate fractional packs or fractional cigars as appropriate, *e.g.*, three and one-half packs would be entered as 3.5. ***This is to be completed for Lung Cancer 2 (LC2) and IR levels I through IV only.***

1. Has the injured party ever Smoked Cigarettes?	Yes _____	No _____
1a. From: _____ / _____	To: _____ / _____	
(month) (year)	(month) (year)	
1b. Packs per day: _____ (use decimal)		

1. Has the injured party ever Smoked Cigars?	Yes _____	No _____
1a. From: _____ / _____	To: _____ / _____	
(month) (year)	(month) (year)	
1b. Cigars per day: _____ (use decimal)		

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Part 8: Employment Information for Economic Loss

This is to be completed for IR claims only.

1. Current Employment Status of the injured party:

- Full-time, outside the home
- Full-time, within the home
- Part-time, outside the home
- Part-time, within the home
- Retired
- Disabled
- Deceased

2. Amount of last annual wages: \$ _____

3. Date of last wage received: _____ / _____
(month) (year)

(Enter current date if currently earning work-related compensation.)

If economic losses are being claimed, you must enclose an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.

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Part 9: Signature Page

All claims must be signed by the claimant, or the person filing on his/her behalf (such as the personal representative or attorney).

If signed by the claimant or the personal representative, I (the claimant or personal representative) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. Upon information and belief, I hereby certify, under penalty of perjury, the information submitted is accurate.

If signed by the claimant's counsel, upon information and belief, I hereby certify, under penalty of perjury, that the information submitted is accurate.

Signature of claimant, personal representative, or claimant's counsel.

Please print the name and relationship to the claimant of the signatory above.

Date: / /
(month) (day) (year)

Please review your submission to ensure it is complete and includes the following documents as applicable.

- Death Certificate (if applicable)
- Certificate of Official Capacity or other estate documentation (if personal representative is filing form) if applicable per state law.
- Medical Records as required by the Trust Distribution Procedures and as requested in the instructions
- Proof of B&W Exposure and Significant Occupational Exposure as required in the Trust Distribution Procedures and requested in the instructions, including affidavits from the injured party or others.
- Documentation of Economic Loss (if Part 8 is applicable)

If you are filing an IR claim and have additional information (see TDP section 5.3(b)(2)) you want the Trust to consider in evaluating your claim, please include these documents with the Claim Form.