PLAQUEMINE DECEMBER 2, 2016 EVENT
PROOF OF CLAIM

A separate Sworn Proof of Claim Form MUST be completed for each Class Member

This document is very important. You MUST COMPLETE AND SUBMIT this proof of claim to be eligible to participate in the settlement. Please type or print legibly. Use extra pages where necessary. When you are finished completing this form, please sign it at the end and initial each page. A separate form must be completed and submitted for each person or entity claiming funds.

I. INDIVIDUAL INFORMATION

A. Class Member Name (Full Legal Name): Gender: Male/Female (circle one if applicable)

_____ _____ _____, _____
First Middle Last Suffix

B. Current Mailing Address (P.O. Box or Street and Number, City, State, Zip)(Where you receive your mail.)

_____
P.O. Box or Street and Number

_____
City, State, Zip

C. Current Physical Address (Street or Road and Number, City, State, Zip)(Where you are living NOW)

_____
Street or Road and Number

_____
City, State, Zip

D. Residence Address on December 2, 2016 (Street /Road, Number, City, State, Zip)(Where were you living on December 2, 2016)

_____
Street or Road and Number

_____
City, State, Zip

E. Date of Birth: _____MM/DD/YYYY Driver's License No.: _____ State: _____

Initial_____

F. Social Security Number: _____ E-MAIL: _____

G. Telephone: _____ Alternate Phone: _____

H. If you are filing this claim form on behalf of a Class Member who is deceased, minor or otherwise incapacitated, please provide the following information:

1. Your information:
   Full Name: _____ SSN: _____ Date of Birth: _____
   Current Mailing Address: _____
   Phone Number: _____

2. What is the status of this person? (Why that person cannot file their own Claim Form.)

Minor □	Incompetent □	Deceased □

3. What is your relationship to the claimant?

Tutor/Tutrix □	Parent □	Power of Attorney □	Spouse □
Legal Guardian□	Curator □	Child □	Other □

II. CLAIM INFORMATION

A. **Resided or Worked in the Area**

1. On December 2, 2022, did you live in the class Area identified by the yellow boundaries on Exhibit 1 to the Settlement Agreement?

_____ Yes _____No

If "Yes," what is the physical address (Street or Road and Number, City, State, Zip) where you lived?

_____

You must attach a Louisiana Driver's License, a State Identification card, or other documentation that shows you actually lived at this address on December 2, 2016

2. On December 2, 2022, were you working in the class Area identified by the yellow boundaries on Exhibit 1 to the Settlement Agreement.

_____ Yes _____No

If "Yes," what is the name of the business at which you were working and provide the physical address (Street or Road and Number, City, State, Zip) where you were working. If you working at an industrial facility, provide the unit or process area where you were working?

Business Name:_____

Physical Address and Unit:_____

You must attach a time card, payroll record or similar record that shows you were actually working in the Area on December 2, 2016.

Initial_____

I do hereby attest that the information contained in the Claim Form is true, accurate and correct to the best of my knowledge. Further, I understand that providing false information on the Claim Form may subject me to criminal and/or civil penalties for perjury, filing false claims, contempt of court, or mail fraud. My signature below indicate that I understand the consequences of making false statements which may subject me to civil and/or criminal penalties.

Claimant/Representative's **Name Printed** (If Claimant is a minor, incompetent, or deceased person, the Guardian/Survivor must include their name)	Claimant/Representative's **Signature** (If Claimant is a minor, incompetent, or deceased person, the Guardian/Survivor must sign)	Date

COMPLETED PROOFS OF CLAIM AND SUPPORTING DOCUMENTATION, IF ANY, MUST BE POSTMARKED ON OR BEFORE OCTOBER 4, 2024, TO:

Plaquemine 2016 Class Settlement Claims Office
338 Lafayette Street
New Orleans, LA 70130

Initial_____

ATTACHMENT 1
AFFIDAVIT OF MEDICARE NON-ELIGIBILITY
(to be filled out ONLY if you had any medical treatment related to the incident)

1. I _____, am over the age of eighteen (18) and am competent to be a witness in this matter. I have personal knowledge of the facts set forth herein.

2. I understand that in reaching a settlement, the parties have considered Medicare's interest in recovering conditional payments made for medical treatment rendered as a result of the claim that is the subject of this litigation.

3. I have provided by Social Security Number and date of birth. I understand that if I am a Medicare beneficiary and I do not provide the requested information, including a Health Insurance Clam Number, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claim(s) correctly and promptly.

4. I hereby make the following representations and warranties in affirming that I am not eligible for Medicare:

   (a) To the best of my knowledge, I am not eligible for Medicare benefits.
   (b) I have not applied for Medicare benefits.
   (c) Medicare has made no conditional payments for any medical expense or prescription expense related to any injury related to this litigation.
   (d) I am not, nor have I ever been a Medicare beneficiary.
   (e) I am not currently receiving Social Security Disability Benefits or Railroad Retirement Benefits.
   (f) I have not applied for Social Security Disability Benefits or Railroad Retirement Benefits.
   (g) I have not been denied Social Security Disability Benefits or Railroad Retirement Benefits.
   (h) I have not appealed from a denial of Social Security Disability Benefits or Railroad Retirement Benefits.
   (i) I am not in End Stage Renal Failure.
   (j) I have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease.
   (k) No liens, including but not limited to liens for medical treatment of any injury related to this litigation, by hospitals, physicians, or medical providers of any kind have been filed for the treatment of injuries sustained as related to this litigation.

5. I assume all responsibility for all liens related to the treatment of any injury related to this litigation, including those asserted by Medicare or any other entity pursuant to Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payor Act.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____
Date of Birth **Social Security Number**

_____ _____
Date **Signature**

Sworn and subscribed before me this _____ day of _____, 2024.

_____
Notary Public
My Commission Expires: _____

Initial_____