

**DII INSUSTRIES, LLC SILICA PI TRUST
UNLIQUIDATED SILICA PI TRUST CLAIM FORM**

Part 4: Diagnosed Silica-Related Injuries

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

<input type="checkbox"/>	Level IV.	Complex Silicosis
<input type="checkbox"/>	Level III.	Lung Cancer
<input type="checkbox"/>	Level II.	Severe Silicosis
<input type="checkbox"/>	Level I.	Silicosis
<input type="checkbox"/>		Mixed Dust Pneumoconiosis

2. Date of Diagnosis ____/____/____

The claims must meet the relevant medical criteria and be supported by appropriate medical documentation as defined in the Trust Distribution Procedures (TDP). The presumptive medical criteria for the Disease Levels set forth above are attached to this Claim Form.

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Part 5: 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 did derived at the time of the injured person's death) at least one-half of their financial support from the injured party.

Also list beneficiaries who are entitled to pursue an action for wrongful death under applicable state law.

If more than four, please photocopy this page, and insert after current page.

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

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

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

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

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Part 6: Company Exposure and Significant Occupational Exposure

Proof of Company Exposure must be enclosed as required by Silica TDP section 4.7(c). (See instructions)

Please photocopy this page and list separately each company site, industry, or occupation where the injured party was exposed to respirable silica.

1. Company Exposure
2. Significant Occupational Exposure.

1. Company Exposure:

- 1a. Name of entity against which claim is asserted (check one): Halliburton
 Harbison-Walker
 Both
- 1b. Name of Plant/Site of Exposure: _____
City: _____ State: _____
- 1c. Date Exposure Began: ____/____/____ (M/Y) Exposure Ended: ____/____/____ (M/Y)
- 1d. Occupation at time of Exposure (e.g., Boilermaker, Laborer, etc.): _____

- 1e. In what state did the injured party reside during this exposure? State: _____
- 1f. Industry in which exposure occurred: _____ (Industry codes listed below.) If code is 26 (other),
specify the industry: _____

Industry Codes

- | | |
|--------------------------------------|--|
| 10. Mining and quarrying | 19. Abrasive materials production |
| 11. Foundry/casting products | 20. Silica products |
| 12. Refractory products | 21. Iron/steel production |
| 13. Boring/drilling/tunneling | 22. Construction (other than sandblasting) |
| 14. Sandblasting | 23. Chemical production |
| 15. Silica abatement | 24. Glass products |
| 16. Clay or ceramic products | 25. Maritime |
| 17. Oil or gas drilling | 26. Other |
| 18. Concrete/gypsum/plaster products | |

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1g. Indicate circumstances of exposure (check all applicable):

- i. Claimant handled respirable crystalline silica on a regular basis; or
- ii. Claimant fabricated silica-containing products such that the claimant, in the fabrication process, was exposed on a regular basis to respirable crystalline silica; or
- iii. Claimant altered, repaired, or otherwise worked with a silica-containing product such that the claimant was exposed on a regular basis to respirable crystalline silica or;
- iv. 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.

2. Significant Occupational Exposure:

Does the exposure described in this Part satisfy the Significant Occupational Exposure requirements described in the Silica TDP section 4.7(b)?

_____Yes _____No

If you are making a claim for Extraordinary Claim treatment, please include a copy of your Social Security Administration employment history.

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Part 7: Exposure to an Occupationally Exposed Person (Bystander)

1. Is the claimant alleging a silica-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 6 must also be completed for each occupationally exposed person.

2. Date Exposure to other person began: _____ / _____ (M/Y)

3. Date Exposure to other person Ended: _____ / _____ (M/Y)

4. Name of occupationally exposed Individual: _____
Last First MI

5. Relationship to occupationally exposed individual:

I am his/her _____.
(brother, son, spouse, etc.)

6. Social Security Number of occupationally exposed individual _____ - _____ - _____

7. Describe how injured party was exposed to the Company product:

Reminder: Part 6 must be completed for the occupationally exposed person.

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4. Have you ever suffered, or been treated for any heart related condition? Yes_____ No_____

If yes, state the diagnosis, the approximate date of diagnosis, and describe the course of treatment for the condition.

4a. Diagnosis: _____

4b. Date of diagnosis: _____/_____/_____

4c. Treatment: _____

5. Do you have a family history of lung cancer? Yes_____ No_____

5a. If yes, identify any relative who suffered from lung cancer and indicate if they were smokers or non-smokers.

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Part 10: Employment Information for Economic Loss

Note: This section is optional and only needs to be completed if you wish this information to be considered in connection with a claim to be processed by Individual Review.

1. Current Employment Status:

- 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:_____/_____(M/Y)

(Enter current month and year if currently earning work-related compensation.)

A W-2 and first page of Form 1040 for last year of full employment must be enclosed if lost wages are being claimed.

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Part 11: 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).

I 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.

Signature of claimant or representative.

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

Date: ____/____/____

Please review your submission to ensure it is complete.

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as required by the Silica TDP and as requested in the instructions.
- Proof of Company Exposure and Significant Occupational Exposure as required in the Silica TDP and requested in the instructions.
- Cover sheet of filed complaint (if Part 9 is applicable).
- W-2 and first page of IRS form 1040 (if Part 10 is applicable)
- Copy of Social Security employment history (if filing for Extraordinary Claim treatment)