DII INDUSTRIES, LLC SILICA PI TRUST

PROOF OF CLAIM FORM
UNLIQUIDATED SILICA PI TRUST CLAIMS

Submit completed claims to:
DII Industries, LLC Silica PI Trust
P.O. Box 106
Wilmington, DE 19899

Instructions for the Claim Form

**** PLEASE NOTE: The Third Amended and Restated Trust Distribution Procedures (TDP), effective March 3, 2023, revised the requirements for exposure evidence under Sections 4.3(a)(3), 4.5, and 4.7(b). Please refer to those Sections, and review the Instructions for Completing Part 5 of the Proof of Claim Form (available on the Trust's website at: http://www.diisilicatrust.com/resources/ documents/) prior to completing this Claim Form. To the extent that this Claim Form conflicts with the TDP, the TDP governs.**

Complete this claim form as thoroughly and accurately as possible. Please type or print neatly. Should there be insufficient space to list all relevant information, please attach additional sheets. In addition to filing the forms that follow, please ensure the following are enclosed, if applicable:

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical records as requested in instructions
- Proof of Company Exposure as set out in the instructions
- Copy of cover sheet of complaint (if applicable – see Part 9 below)
- Copy of W-2 and first page of IRS Form 1040 (if applicable – see Part 10 below)
- Copy of Social Security employment history (if filing for Extraordinary Claim treatment)

Part 1: Representation

If counsel represents claimant, please print or type the following information:

1. Attorney name:_____
   Last First MI
2. Name of Law Firm:_____
3. Firm Address:_____
4. Attorney Phone:_____ Fax:_____ Email:_____
5. Paralegal or Contact Name:_____
   Last First MI
6. Contact Phone:_____ Fax:_____ Email:_____
7. Attorney's or Law Firm's Tax ID Number:_____

Part 2: Choice of Claim Process

Please choose the applicable claim process (choose only one):

☐ 1. Expedited Review
☐ 2. Individual Review
☐ 3. Extraordinary Claim (must undergo Individual Review)
☐ 4. Exigent Claim (must undergo Individual Review and complete a Supplemental Proof of Claim Form)

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Part 3: Injured Party Information

1. Name:_____ 2. Social Security #: _____-_____-_____
Last First MI

3. Gender: Male _____ Female _____ 4. Date of Birth: _____/_____/_____

5. Is injured party living? Yes_____ No _____

6. If injured party is living and not represented by counsel, please complete the following:

6a. Mailing address_____

_____

6b. Daytime Phone: ( ) _____- _____

7. If injured party is deceased, please complete the following: (Death Certificate must be enclosed)

7a. Date of death: _____/_____/_____

7b. Was death silica-related? Yes _____ No _____

8. If injured party has personal representative other than, or in addition to, his/her attorney, please indicate the following for the representative (Certificate of Official Capacity must be enclosed)

8a. Name:_____
Last First MI

8b. Social Security #:_____-_____-_____

8c. Mailing Address:_____

_____

8d. Daytime Phone: ( ) _____ - _____

8e. Relationship to injured party:_____
(spouse, child, other)

9. Injured party's current or last State of residence:_____

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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.)

☐	Level IV.	Complex Silicosis
☐	Level III.	Lung Cancer
☐	Level II.	Severe Silicosis
☐	Level I.	Silicosis
☐		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 derive 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: _____ (Last / First / MI) 2. Date of Birth: ___/___/____

3.Relationship ☐ Spouse ☐ Child ☐ Other _____ 4. Financially Dependent: ☐ Yes ☐ No

1. Name: _____ (Last / First / MI) 2. Date of Birth: ___/___/____

3. Relationship: ☐ Spouse ☐ Child ☐ Other _____ 4. Financially Dependent: ☐ Yes ☐ No

1. Name: _____ (Last / First / MI) 2. Date of Birth: ___/___/____

3.Relationship: ☐ Spouse ☐ Child ☐ Other _____ 4. Financially Dependent: ☐ Yes ☐ No

1. Name: _____ (Last / First / MI) 2. Date of Birth: ___/___/____

3. Relationship: ☐ Spouse ☐ Child ☐ Other _____ 4. Financially Dependent: ☐ Yes ☐ No

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Part 6: Company Exposure and Significant Occupational Exposure

****NOTE: Please refer to TDP Sections 4.3(a)(3), 4.5, and 4.7(b), and review the Instructions for Completing Part 5 of the Proof of Claim Form (available on the Trust's website at: http://www.diisilicatrust.com/resources/ documents/) prior to completing this Section.**

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		
15.	Silica abatement	23.	Chemical production
16.	Clay or ceramic products	24.	Glass products
17.	Oil or gas drilling	25.	Maritime
18.	Concrete/gypsum/plaster products	26.	Other

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 <u>must</u> be completed for the occupationally exposed person.

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Part 8: Smoking and Disease History

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.

For each item, indicate whether injured party has smoked or used the given product. If cigarettes were smoked, indicate the dates they were used, and the amount per day. Indicate fractional packs as appropriate, *e.g.*, three and one-half packs would be entered as 3.5.

1. Has the injured party ever **Smoked Cigarettes?** Yes_____ No_____

   1a. From: _____/_____(M/Y) To: _____/_____ (M/Y)

   1b. Packs per day:_____ (use decimal)

2. Has the injured party ever **Smoked Cigars?** Yes_____ No_____

   2a. From: _____/_____ (M/Y) To: _____/_____ (M/Y)

   2b. Cigars per day: _____ (use decimal)

3.. Have you ever been diagnosed with any lung disease or illness other than your silica related claim? Yes _____ No _____

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

3a. Diagnosis:_____

3b. Date of diagnosis:_____/_____/

3c. Treatment:_____

_____

_____

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.

_____

_____

_____

_____

Part 9: Litigation/Claims History

1. Has a silica-related lawsuit ever been filed on behalf of the injured party? Yes____No _____

2. State of residence of the claimant when lawsuit filed: _____

3. State in which the suit was originally filed:_____

4. Name of court in which the suit was originally filed:_____

5. Case number:_____

6. Date the suit was originally filed: _____/_____ (M/Y)

7. Has injured party received settlement money from a Halliburton Entity and/or a Harbison-Walker entity or their predecessors, successors, and assigns? Yes____ No____

8. What is the current status of this suit? ☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment

Please attach a photocopy of the endorsed cover sheet of the filed complaint.

Note: The questions below are optional and only need to be completed if you wish this information to be considered in connection with a claim to be processed by Individual Review.

9. List the defendants named in the above lawsuit(s) and the status of suit for each defendant.

Defendant	Status
9a._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
9b._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
9c._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
9d._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment

10. List the silica and asbestos trusts against which you have made a claim and the status of the claim for each trust.

10a._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
10b._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
10c._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment
10d._____	☐ Withdrawn/dismissed ☐ Judgment ☐ Pending ☐ Settled for payment

If more space is needed, please photocopy this page and insert after current page.

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)