

**GST SETTLEMENT FACILITY  
PROOF OF CLAIM FORM  
Instructions for Filing this Claim Form**

This form may be used to file a claim with the GST Settlement Facility (the "Trust"), but it is not the only method for doing so. The Trust provides tools for filing claims electronically, and use of these tools is strongly encouraged. Please visit [www.Verusllc.com](http://www.Verusllc.com) for instructions on how to submit claims and supporting documents electronically.

If this claim is not in compliance with the Asbestos Claims Bar Date, and relief has not been obtained from the Bankruptcy Court, the claim is NOT eligible for payment by the Trust.

Please complete this claim form as thoroughly and accurately as possible. Type your responses, or, print neatly. Should there be insufficient space to list all relevant information, please attach additional sheets.

***If this claim form or supporting documentation is found to be incomplete or deficient, you will have six (6) months to respond or your claim will be rejected.***

To the extent this form conflicts with the Claims Resolution Procedures (the "CRP"), the CRP controls.

<b>Part 1: Claim Information</b>	
Claim Type <input type="checkbox"/> Expedited <input type="checkbox"/> Extraordinary	Exigency <input type="checkbox"/> Not Applicable <input type="checkbox"/> Hardship Claim <i>(For Hardship Claims, evidence of financial need, based on claimant's expenses and all sources of available income, and evidence that the financial condition is a result of claimant's asbestos-related disease, is required.)</i>

<b>Part 2: Injured Party Information</b>			
Last Name	First Name	MI	Suffix
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number/Tax ID	Date of Birth (mm/dd/yyyy)	Date of Death (if applicable) (mm/dd/yyyy)
Check box if Death was Asbestos Related <input type="checkbox"/>	Firm Matter Number (if applicable)		Check box if Injured Party is Living <input type="checkbox"/>
Check box if injured party's Coltec/GST Product Contact ended before December 5, 1980. <input type="checkbox"/> <i>(Please note that if a claimant is unable or chooses not to answer, the Trust will presume exposure on or after December 5, 1980 for Medicare Reporting purposes only. This presumption will not affect the calculation of an injured party's exposure for purposes of meeting the CRP's exposure requirements.)</i>		Medicare Health Insurance Claim Number (HICN) (if applicable and known)	

*Mailing Address (if not represented by counsel)*

Address			
City	State	ZIP	Country

Phone (    ) _____ - _____	Email
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### Part 3: Law Firm Representation

Please provide the following information if the claimant is represented by counsel.

Law Firm Name	Check box if seeking to elect higher law firm factor consideration. <input type="checkbox"/> (If claimant believes based on historical settlements by law firm (during previous 5 years before bankruptcy filing) that a higher value is justified, evidence of such belief must be provided.)	
Mailing Address		
City	State	ZIP
Attorney Last Name	Attorney First Name	Attorney MI
Phone (    ) _____ - _____	Fax (    ) _____ - _____	Email

### Part 4: Asbestos-Related Injury Information

Please indicate the **highest disease level** for which you believe this claim could be compensated, based on the required evidentiary criteria. The claim must meet the relevant medical criteria and be supported by appropriate medical documentation as defined in the CRP.

Scheduled Disease Level	Date of Diagnosis
<input type="checkbox"/> Malignant Mesothelioma <input type="checkbox"/> Asbestos-Related Lung Cancer <input type="checkbox"/> Severe Asbestosis <input type="checkbox"/> Asbestos-Related Other Cancer (Please specify: _____) <input type="checkbox"/> Disabling Asbestosis <input type="checkbox"/> Non-Disabling Asbestosis	_____ / _____ / _____ (Month)    (Day)    (Year)

### Part 5: Personal Representative (if applicable)

Please provide the following for the representative. (Certificate of Official Capacity or other estate documentation must be enclosed if applicable per state law.)

Last Name	First Name	MI	Suffix
Mailing Address			
City	State	ZIP	Country
Phone (    ) _____ - _____	Social Security Number/ Tax ID	Email	

## Part 6: Asbestos Litigation and Claims History

1. Check box if an asbestos-related lawsuit has ever been filed on behalf of the injured party. 
  - a. Check box if Coltec/GST was named as a defendant.
  - b. State in which the suit was originally filed: \_\_\_\_\_
  - c. Name of the court in which the suit was originally filed: \_\_\_\_\_
  - d. Case Number: \_\_\_\_\_
  - e. Date the suit was originally filed: \_\_\_\_\_
  - f. Check box if the claimant or injured party has ever received money from Coltec/GST regarding this suit.
  - g. Check box if the claimant or injured party has signed a release releasing Coltec/GST regarding this suit.
2. If 1(a) above is checked, check box if a final non-appealable judgment was entered. 
  - a. If a final non-appealable judgment was entered, provide a copy of the judgment.
  - b. Check box if a final non-appealable judgment was not entered, but an appeal by Coltec/GST or the plaintiff in connection with the suit was filed.
  - c. If the 2(b) above is checked, please provide the case number of the appeal and indicate whether a letter of credit, appeal bond, supersedeas bond or other security or surety was issued in connection with the appeal, verdict, or judgment.  
\_\_\_\_\_
3. If box for 1(a) is not checked, in which state/jurisdiction would the claimant qualify to be evaluated? \_\_\_\_\_  
Please select one:
  - a. Is this the state/jurisdiction where the claimant resided at the time of diagnosis?
  - b. Is this the state/jurisdiction where the claimant resided at the time of filing this claim?
  - c. Is this the state/jurisdiction where the claimant had Coltec/GST Product Contact?
4. Check box if seeking to elect higher jurisdiction factor consideration.   
If claimant believes based on historical settlements in jurisdiction that a higher value is justified, evidence of such belief must be provided.
5. Check box if diagnosis of an asbestos-related disease was before August 1, 2014 and a claim was filed with the Bankruptcy Court. 
  - a. Date of filing with Bankruptcy Court: \_\_\_\_\_  
*Please submit a copy of the proof of claim filed with the Bankruptcy Court.*
6. Check box if a tolling agreement for the injured party was ever in effect with respect to the claim(s) against Coltec/GST.   
Please submit copy of tolling agreement
  - a. Date tolling agreement began: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month) (Day) (Year)
  - b. Date tolling agreement ended: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month) (Day) (Year)
7. Check box if a claim was filed with Coltec/GST pursuant to an administrative settlement agreement. 
  - a. Date the claim was originally filed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month) (Day) (Year)
  - b. Check box if money has ever been received from Coltec/GST regarding this claim.
8. Check box if the claimant or injured party ever applied for Workers' Compensation benefits resulting from the injured party's exposure to asbestos dust or fibers while working as an employee of Coltec/GST.
9. Check box if the claimant or injured party has ever been granted Workers' Compensation benefits related to the injured party's exposure to Coltec/GST products.

**Part 7: Secondary Coltec/GST Product Contact**

*If the claimant alleges malignant mesothelioma resulting solely or in part from exposure to an occupationally exposed person, such as a family member, please complete this section. Part 8 must also be completed for each occupationally exposed person.*

**Occupationally Exposed Individual 1**

Last Name	First Name	MI	Suffix
Relationship to the Injured Party	Date Exposure to this Individual Began (mm/dd/yyyy)	Date Exposure to this Individual Ended (mm/dd/yyyy)	
Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the Trust is alleged to be legally responsible.			

**Occupationally Exposed Individual 2**

Last Name	First Name	MI	Suffix
Relationship to the Injured Party	Date Exposure to this Individual Began (mm/dd/yyyy)	Date Exposure to this Individual Ended (mm/dd/yyyy)	
Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the Trust is alleged to be legally responsible.			

**Occupationally Exposed Individual 3**

Last Name	First Name	MI	Suffix
Relationship to the Injured Party	Date Exposure to this Individual Began (mm/dd/yyyy)	Date Exposure to this Individual Ended (mm/dd/yyyy)	
Description of how the injured party was exposed through this individual to asbestos or asbestos-containing products for which the Trust is alleged to be legally responsible.			

## Part 8: Coltec/GST Product Contact

List all occupations and industries during which the injured party or an occupationally exposed individual with whom the injured party came into contact had Coltec/GST Product Contact, which Coltec/GST Product Contact could have credibly contributed to causing his or her asbestos-related condition. Submit supporting documentation in conjunction with each entry provided as required by CRP section 6.7(b).

Please include information for all sites at which exposure occurred as well as all sites at which the injured party/occupationally exposed individual was employed contemporaneous to when exposure occurred. If it is necessary to add additional exposure records, attach more copies of this page to the claim form as needed.

### Exposure 1

First Date of Exposure (mm/yyyy)	Last Date of Exposure (mm/yyyy)	<i>If exposure occurred aboard a ship at sea, provide number of days:</i>	
Occupation	Job Title		
Contact <b>Code</b> from Contact Group List (Appendix IV)	If Other (G-61), please describe		
Industry <b>Code</b> (codes listed below)	If Other (Code 37), please describe		
Types of all Coltec/GST asbestos-containing products or materials to which injured party was exposed and for which injured party alleges the Trust is legally responsible:			
Describe manner of Coltec/GST Product Contact to above product(s):			
Job Site/Ship Name	Address	Employer	
City	State	ZIP	Country
If this is a Secondary Exposure claim, please enter the name of the Occupationally Exposed Person and complete Part 7:			
First Name: _____		Last Name: _____	

### Exposure 2

First Date of Exposure (mm/yyyy)	Last Date of Exposure (mm/yyyy)	<i>If exposure occurred aboard a ship at sea, provide number of days:</i>	
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Occupation		Job Title (if different from Occupation)	
Contact <b>Code</b> from Contact Group List (Appendix IV)		If Other (G-61), please describe	
Industry <b>Code</b> (codes listed below)		If Other (Code 37), please describe	
Types of all Coltec/GST asbestos-containing products or materials to which injured party was exposed and for which injured party alleges the Trust is legally responsible:			
Describe manner of Coltec/GST Product Contact to above product(s):			
Job Site/Ship Name	Address	Employer	
City	State	ZIP	Country
If this is a Secondary Exposure claim, please enter the name of the Occupationally Exposed Person and complete Part 7:			
First Name: _____		Last Name: _____	

### Exposure 3

First Date of Exposure (mm/yyyy)	Last Date of Exposure (mm/yyyy)	<i>If exposure occurred aboard a ship at sea, provide number of days:</i>	
Occupation		Job Title (if different from Occupation)	
Contact <b>Code</b> from Contact Group List (Appendix IV)		If Other (G-61), please describe	
Industry <b>Code</b> (codes listed below)		If Other (Code 37), please describe	
Types of all Coltec/GST asbestos-containing products or materials to which injured party was exposed and for which injured party alleges the Trust is legally responsible:			
Describe manner of Coltec/GST Product Contact to above product(s):			
Job Site/Ship Name	Address	Employer	
City	State	ZIP	Country

If this is a Secondary Exposure claim, please enter the name of the Occupationally Exposed Person and complete Part 7:

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

**Industry Codes**

- |   |                                     |
|---|-------------------------------------|
| 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. Commercial Construction             | 32. Tire & rubber                   |
| 18. Iron/steel                          | 33. Utilities                       |
| 19. Longshore                           | 34. Asbestos products manufacturing |
| 20. Maritime                            | 36. Building occupant/bystander     |
| 21. Military (e.g. Army, Navy, etc.)    | 37. Other                           |
| 23. Non-asbestos products manufacturing |                                     |

**Part 9: Economic Loss**

*If economic losses in excess of \$200,000 are being claimed, please submit an economic report, IRS Form W-2, the first page of IRS Form 1040, or other relevant supporting documentation.*

Is the Injured Party claiming economic Loss in excess of \$200,000?     Yes     No

Please provide the total claimed economic loss amount if in excess of \$200,000: \$ \_\_\_\_\_

Current Employment Status of the Injured Party:

- |                                    |                                     |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Full-time | <input type="checkbox"/> Disabled   |
| <input type="checkbox"/> Part-time | <input type="checkbox"/> Deceased   |
| <input type="checkbox"/> Retired   | <input type="checkbox"/> Unemployed |

Amount of last annual wages:

\$ \_\_\_\_\_

Date of last wage received (mm/dd/yyyy)

**Part 10: Financial Dependents**

*List all persons who are, or were at the time of diagnosis of the asbestos-related disease claimed, financially dependent upon the injured party for at least one-half of their financial support. 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.*

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

**Financial Dependent 1**

Last Name	First Name	Middle Initial	Suffix
Date of Birth (mm/dd/yyyy)	Relationship	<input type="checkbox"/> Spouse	<input type="checkbox"/> Minor child
		<input type="checkbox"/> Adult disabled dependent	<input type="checkbox"/> Other _____

**Financial Dependent 2**

Last Name	First Name	Middle Initial	Suffix
Date of Birth (mm/dd/yyyy)	Relationship	<input type="checkbox"/> Spouse	<input type="checkbox"/> Minor child
		<input type="checkbox"/> Adult disabled dependent	<input type="checkbox"/> Other _____

**Financial Dependent 3**

Last Name	First Name	Middle Initial	Suffix
Date of Birth (mm/dd/yyyy)	Relationship	<input type="checkbox"/> Spouse	<input type="checkbox"/> Minor child
		<input type="checkbox"/> Adult disabled dependent	<input type="checkbox"/> Other _____

**Part 11: Declaration and Signature**

***All claims must be signed under penalty of perjury by the claimant, the claimant's attorney, or the personal representative (or equivalent) signing on the claimant's behalf.***

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. I certify that the injured party's exposure to Coltec/GST product(s) could have credibly contributed to causing the asbestos-related condition alleged herein. I hereby certify, under penalty of perjury, that the information submitted is truthful and accurate.

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

Signature of Claimant, Claimant's Representative or Claimant's Counsel	Date
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Print Name Here	Relationship to Injured Party
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**Please review your submission to ensure it is complete and includes the following documents as applicable.**

- Filing fee required for injury being alleged
- 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 CRP
- Proof of Coltec/GST Product Contact as required in the CRP, including affidavits or sworn statements from the injured party or others
- Copy of the tolling agreement (if applicable)
- Documentation of economic loss (if in excess of \$200,000)
- Any additional information you wish to provide

**If you have additional information you want the Trust to consider in evaluating the claim, please include these documents with this claim form.**

**To file by mail, send this completed form and all supporting documentation to:**

GST Settlement Facility  
c/o Verus Claims Services, LLC  
3967 Princeton Pike  
Princeton, NJ 08540

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