PLAQUEMINE APRIL 18, 2022 EVENT
PROOF OF CLAIM

A separate Sworn Proof of Claim Form MUST be completed for each Claimant (including children) seeking payment

You MUST FILL OUT, SIGN, AND SUBMIT this Proof of Claim by the claim deadline to be eligible to participate in the settlement. (Individuals under age 18 must have a form filed out by a parent or legal guardian.)

I. CLAIMANT INFORMATION

Claimant's Full Legal Name: _____ _____ _____, _____
First Middle Last Suffix

Gender: ☐ Male ☐Female

Current Mailing Address: _____

_____

Current Physical Address: _____
(if different from mailing address)

_____

Date of Birth: _____/_____/_____ Driver's License No.: _____ State: _____
(MM/DD/YYYY)

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

Primary Telephone: **(_____)**_____ Alternate Telephone: **(_____)**_____

II. REPRESENTATIVE INFORMATION (IF APPLICABLE)

If the person filling out this form is making a claim for someone who CANNOT fill out the form for themselves due to age or mental capacity, you must also provide the following information. **You must also submit documents establishing your relationship to the claimant** (e.g., birth certificate, court records, school records, financial records, medical records, power of attorney, court order, etc.):

Representative's name: _____ Representative's telephone: **(_____)**_____

Representative's address: _____

_____

Relationship to Claimant: ☐ Parent ☐ Spouse ☐Executor/Succession Rep. ☐ Legal Guardian
☐ Curator ☐ Tutor/Tutrix ☐ Power of Attorney ☐Provisional Custody
☐ Other (explain):_____

III. CLAIM INFORMATION

You must provide an answer to each one of Parts A, B, C, and D below.

The "*Event*" is the fire and chlorine release from Blue Cube Operations, LLC's facility with The Dow Chemical Company complex at approximately 8:30 p.m. on April 18, 2022.

A. I was physically located at the following address within an area included in the class between April 18, 2022, 8:30 p.m., and April 19, 2022, 5:22 p.m.:

Street or Road and Number: _____

City, State, Zip _____

B. **CHOOSE ONE OF THE FOLLOWING:**

The address where I was physically located listed above in Part A is:

☐ My home. **I understand that I must also provide proof that I lived at this address at the time of the Event (such as a copy of my driver's license, a utility bill, a tax bill, proof that a minor for whom I am making a claim resided with me, etc.)**

OR

☐ My workplace: **I understand that I must provide proof that I was working at the time of the Event (such as a timecard, payroll record, employer affidavit, etc.)**

OR

☐ Other (Describe—e.g., place of business, friend/relative home, etc.): _____
I understand that I must provide proof that I was present at this location at the time of the Event (a record of relevant medical treatment on April 18, 19, or 20, 2022, identifying the incident, which shall qualify as proof while other evidence will be considered as well).

C. **CHOOSE ONE OF THE FOLLOWING:**

Between April 18, 2022, 9:00 p.m. to 9:30 p.m., I, or someone I was present with, received a phone call or text message from the Iberville Parish Office of Emergency Preparedness advising of the chemical release and ordering me to shelter-in-place.

☐ **Yes**, I received a call or text to shelter in place at this phone number: (_____)_____

☐ **Yes**, the following person who was present with me received a call or text on their phone to shelter in place:

Name:_____ Phone Number: (_____)_____

☐ **No**, I did not receive a call or text to shelter in place.

D. **CHOOSE ONE OF THE FOLLOWING IF YOU WANT TO PARTICIPATE IN THE SETTLEMENT** :

☐ **Option 1: Standard Class Settlement Claims**: I experienced emotional damages (fear, freight, and/or inconvenience) and/or brief discomfort but did not seek medical treatment from the ***Event,*** and I want to submit a claim for compensation to be awarded by a Special Master based upon my location during the ***Event***.

OR

☐ **Option 2: Claims for Other Injuries, Medical Expenses, Property Damage and/or Lost Wages**: **If I select this option, I must meet all criteria to qualify for Option 1, but in addition, I must also provide additional documentation to prove the additional claims I make.** I want to submit more evidence to be considered by a Special Master, who may or may not award any amounts or any additional amounts (select each that applies and for which I will submit evidence):

- ☐ Additional injuries and/or medical expenses: **Complete Schedule A (and Schedule B, if applicable)**
- ☐ Property damages: **Complete Schedule C**
- ☐ Lost wages: **Complete Schedule D**

As class counsel, we recommend that you participate in the settlement as an easy and efficient means of recovery. To make an individual claim, see instructions on the next page.

IV. ATTESTATION

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

All pages submitted are also initialed as verification that the information provided is true, accurate, and correct to the best of my knowledge.

_____	_____	_____
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

SUMMARY OF PROCEDURES AND REMINDERS

COMPLETED PROOFS OF CLAIM AND SUPPORTING DOCUMENTATION MUST BE POSTMARKED OR HAND DELIVERED ON OR BEFORE September 26, 2025, TO:

Plaquemine 2022 Class Settlement Claims Office
23465 Railroad Avenue
Plaquemine, Louisiana 70764

OR

YOU MAY ALSO SUBMIT YOUR PROOF OF CLAIM AND SUPPORTING DOCUMENTATION ONLINE BY THE DEADLINE AT WWW.PLAQUEMINE2022INCIDENT.COM

If you do not submit a claim form and select either Option 1 or Option 2, you cannot recover under the settlement, AND you will be precluded from filing or proceeding with a lawsuit unless you have properly opted out.

If you selected Option 1, remember to include any documents required by Part B to support your claim (and, if acting in a representative capacity, documents establishing your relationship to the claimant) before you mail or submit your claim form in person at the above-listed address or online at www.plaquemine2022incident.com.

If you selected Option 2, in addition to the documents required by Part B (and, if acting in a representative capacity, documents establishing your relationship to the claimant), you must complete the additional schedules indicated for each of the categories of damages you selected under Part D, and also submit documentation to support your claim. These schedules are available online at www.plaquemine2022incident.com.

If you selected Option 1 or 2 and provided the necessary documentation, you do not need to take any other steps unless requested by Class Counsel or by the Special Master. Once final approval is achieved, if you qualify for the settlement, you will then receive a check for the amount set forth in the agreement or as determined by the Special Master.

OBJECTIONS: Only if you select Option 1 or Option 2 can you still file an objection to the settlement. To make an objection, you must do so in writing and provide all of the required information to the address stated in the detailed notice.

OPT-OUTS: If you opt out of the class settlement you forfeit the rights to recover under this settlement. To opt out, send a written request and provide all of the required information to the address stated in the detailed notice.

FOR MORE INFORMATION SEE THE DETAILED NOTICE AVAILABLE AT WWW.PLAQUEMINE2022INCIDENT.COM

PLAQUEMINE APRIL 18, 2022 EVENT
SCHEDULE A – MUST BE COMPLETED ONLY IF YOU CHOSE OPTION 2 AND YOU ARE MAKING A CLAIM FOR MEDICAL EXPENSES

Please complete the following related to your claim for personal injuries:

Full Name: _____

Please describe all symptoms, conditions, etc. you suffered as a result of the *Event:*

_____

_____

_____

_____

Have you seen any doctor(s) or otherwise sought medical treatment for this/these personal injuries?

_____ Yes _____ No

If yes, please provide:

Doctor's Name: _____

Doctor's Address: _____

_____

Doctor's Phone Number: _____

Reason for your Visit: _____

Any Diagnosis given by the Doctor: _____

Date(s) Seen: _____

Cost of Treatment: _____

Medicare:

Are you Medicare eligible?[1] _____ Yes _____ No

If you answered "No" (that is, you are not Medicare eligible), complete Schedule B.

Are you currently or have you been qualified or been enrolled in Medicare Part A, B, C, or D? _____ Yes _____ No

If you answered "Yes", what is your Health Insurance Claim Number (HCIN): _____

[1] You are considered Medicare eligible if (i) you are age 65 or older; (ii) you have applied for Medicare at any time; (iii) you have been on Social Security disability for 24 months; (iv) you have Lou Gehrig's Disease (ALS); (v) you have End Stage Renal Disease; or (vi) you are receiving railroad retirement disability benefits.

Are you a member of a Medicare Advantage Plan? _____ Yes _____ No

If you answered "Yes", provide the following:
Name of the plan _____ Plan number: _____

Are you currently receiving or have you received any
Medicaid assistance? _____ Yes _____ No

If you answered "Yes", what is the Medicaid Number assigned to you: _____

Payment of settlement funds will be reported to Medicare if you are in the Medicare system either because you applied for Medicare in the past or you are Medicare eligible. If you have ever applied for Social Security disability, your name may be in the Medicare system and, if so, payment of settlement funds may be reported to Medicare.
Class Member identifying information will be provided to the Centers for Medicaid Services ("CMS") in order to report payment of settlement funds to the CMS.

You must include any and all medical records and medical bills from the doctors/hospitals/clinics you saw as a result of the *Event.*

ATTACH ALL SUPPORTING DOCUMENTATION

PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY

PLAQUEMINE APRIL 18, 2022 EVENT
SCHEDULE B
DECLARATION 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 declaration are true.

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

_____ _____
Date **Signature**

PLAQUEMINE APRIL 18, 2022 EVENT
SCHEDULE C
PROPERTY DAMAGE CLAIM

If you claim that you had property damaged due to the *Event*, please complete the following:

Full Name: _____

Property Address: _____
Municipal No., Street/Road/Apt.

_____
City/Town *State* *Zip Code*

Please describe in detail all damages to your property caused by the Event, including identification of the property damaged, date(s) that damage occurred, repairs required, etc.:

_____

_____

_____

_____

_____

_____

ATTACH ALL SUPPORTING DOCUMENTATION INCLUDING PHOTOGRAPHS OF DAMAGES, ESTIMATES OF REPAIRS, INVOICES FROM REPAIRS, RECEIPTS FROM PAYMENTS FOR REPAIRS

PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY

PLAQUEMINE APRIL 18, 2022 EVENT
SCHEDULE D
LOSS OF WAGES OR INCOME

If you claim that you lost wages or income due to the *Event*, please complete the following:

Full Name: _____

Name of Employer in April 2022: _____

Employer's Address: _____
Municipal No., Street/Road/Apt.

_____
City/Town *State* *Zip Code*

Your Position/Job Title: _____

Your Supervisor: _____

Supervisor's Phone Number: _____

Hourly wage in April 2022 (or, if salaried, annual salary): _____

Date first employed with Employer: _____

Are you still employed with Employer? _____ Yes _____ No

Please describe in detail why you contend you are entitled to damages for a loss of wages or income, including all hours and specific dates you missed work, the reason why you missed work, the specific amount of wages or income which you contend you lost:

_____

_____

_____

_____

_____

_____

ATTACH ALL SUPPORTING DOCUMENTATION, INCLUDING ANY CHECK STUBS

PLEASE ATTACH ADDITIONAL PAGES IF NECESSARY