

CLAIM FORM & CERTIFICATION FOR
LESLIE CONTROLS, INC.
ASBESTOS PERSONAL INJURY TRUST

Submit claims to:

Website- lesliecontrolsasbestostrust.com

Or

Email- leslieinquiries@mfrclaims.com

Or

Mail to-

**Leslie Controls, Inc. Asbestos Personal Injury Trust
c/o MFR Claims Processing, Inc.
115 Pheasant Run
Suite 212
Newtown, PA 18940**

For additional information, please refer to the **Instructions for Filing a Claim with the Leslie Controls, Inc. Asbestos Personal Injury Trust** and the **Leslie Controls, Inc. Asbestos Personal Injury Trust Distribution Procedures (the “TDP”)**.

**CLAIM FORM & CERTIFICATION FOR
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Part 1: INJURED PARTY and CLAIM INFORMATION

1.1 Claim Type:

- Leslie Powerhouse and Below-Deck Naval Station Claim

Check all that apply:

The Injured Party performed or was in the immediate vicinity of a worker who performed:

- installation, maintenance or removal of Leslie valves
 installation, maintenance or removal of other control equipment manufactured by Leslie identified as: _____

which occurred while the Injured Party was:

- regularly employed in a Leslie Powerhouse;
identify the Leslie Powerhouse(s): _____
 in a United States shipyard while working on naval vessels;
identify the shipyard(s) and/or vessel(s): _____
 serving at an assigned Below-Deck Naval Station;
identify the Below-Deck Naval Station(s): _____
 other (please specify): _____

- Leslie Construction and Maintenance Claims

1.2 Injured Party's Full Name: _____
[First Name] [Middle Name] [Last Name]

SSN: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
Month Day Year

Gender: M F

1.3 Is the Injured Party Living? Yes No

If No, provide the following:

Date of Death: _____ / _____ / _____
Month Day Year

Official Representative's Full Name: _____
[First Name] [Middle Name] [Last Name]

Also provide Death Certificate and one of the Following:

- Certificate of Official Capacity
- Other applicable document authorizing a person to act on behalf of the Injured Party
- Official Representative Certification (below) signed by Attorney

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Official Representative Certification

This certification eliminates the need for any documentation of authority on behalf of a deceased claimant.

Attorney certifies that this claim is filed on behalf of the Official Representative acting for the Injured Party and that the Official Representative has official capacity to file this claim based on the operation of law.

Signature of Attorney

Printed Name

1.4 Injured Party's Law Firm Contact Information

Firm Name: _____

Attorney Name: _____ Phone Number: _____

Para/Admin Name: _____ Phone Number: _____

Address: _____

Email Address: _____

1.5 Review of claim:

(a) Expedited and Individual Review: Please check the appropriate box:

- Expedited Review
- Individual Review *(Complete Part 7 of this Claim Form)*

(b) Please check the box(es) for any of the following features that apply:

- Secondary Exposure Claim
- Extraordinary Claim
- Exigent Health Claim
- Exigent Hardship Claim
- Foreign Claim

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1.6 Has the Injured Party ever received money for an asbestos-related injury or claim from Leslie Controls, Inc.?

Yes No

1.7 Has the Injured Party ever entered into a release of Leslie Controls, Inc. for an asbestos-related injury or claim? If yes, provide a copy of the release.

Yes No

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Part 2: DIAGNOSED DISEASES

2.1 DISEASE CLAIMED

Check the box indicating the highest disease level claimed by the Injured Party for which there is attached medical evidence to support the claim. Provide the date of first diagnosis for the disease claimed.
See Instructions for Filing a Claim With the Leslie Controls, Inc. Asbestos Personal Injury Trust for the applicable medical evidence required for each disease.

Disease Level I	<u>First Date of Diagnosis</u>
<input type="checkbox"/> Asbestosis/Pleural Disease I	____/____/____
Disease Level II	
<input type="checkbox"/> Asbestosis/Pleural Disease II	____/____/____
Disease Level III	
<input type="checkbox"/> Severe Asbestosis	____/____/____
Disease Level IV Other Cancer	
<input type="checkbox"/> Colorectal Cancer	____/____/____
<input type="checkbox"/> Esophageal Cancer	____/____/____
<input type="checkbox"/> Laryngeal Cancer	____/____/____
<input type="checkbox"/> Pharyngeal Cancer	____/____/____
<input type="checkbox"/> Stomach Cancer	____/____/____
Disease Level V	
<input type="checkbox"/> Lung Cancer 2	____/____/____
Disease Level VI	
<input type="checkbox"/> Lung Cancer 1	____/____/____
Disease Level VII	
<input type="checkbox"/> Mesothelioma	____/____/____

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2.2 Has the Injured Party been diagnosed with a Scheduled Disease other than the diagnosis identified above? This request excludes medical or legal evaluations by purely consulting experts that are protected by a privilege under applicable state law that has not been waived.

Yes No

If the answer is "Yes", please provide a copy of the report that makes the diagnosis, even if it was made by one of the unacceptable doctors or medical facilities listed in the Instructions.

Please check this box if the Injured Party or Claimant filed a claim against Leslie Controls, Inc. or any other asbestos defendant in the tort system before July 12, 2010 and filed a physical examination report with another asbestos-related personal injury settlement trust or has available such a report by an examining physician engaged by the claimant or his or her law firm.

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Part 3: STATUTE OF LIMITATIONS

3.1 In which state does the Injured Party currently reside or, if deceased, in which state did the Injured Party reside at time of death? _____

3.2 Does a tolling agreement apply? Yes No

If Yes, provide a copy of the tolling agreement.

If an asbestos-related lawsuit has been filed against Leslie Controls, Inc. on behalf of the Injured Party, please provide the following:

3.3 Where was the lawsuit filed? City: _____ County: _____ State: _____

Name of Court: _____

3.4 Date on which the lawsuit was originally filed: ____ / ____ / ____

3.5 Provide the Docket or Case Number of the lawsuit: _____

3.6 Was a final non-appealable judgment entered against Leslie Controls, Inc. in the lawsuit?

Yes No

3.7 Jurisdiction Selection

If no lawsuit has ever been filed against Leslie Controls, Inc. on behalf of the Injured Party, indicate the state/jurisdiction elected as the Claimant's Jurisdiction: _____

Jurisdiction elected is (please check one of the following):

- The jurisdiction in which the Injured Party resided at the time of diagnosis.
- The jurisdiction in which the Injured Party resides when this claim is filed with the Trust.
- A jurisdiction in which the Injured Party experienced exposure to an asbestos-containing product, or to conduct that exposed the Injured Party to an asbestos-containing product, for which Leslie Controls, Inc. has legal responsibility.
- Pennsylvania, because all jurisdictions which could otherwise be elected describe the claim as one for "exemplary" or "punitive" damages.

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**Part 4: LESLIE CONTROLS SPECIFIC OCCUPATIONAL EXPOSURE
AND SIGNIFICANT OCCUPATIONAL EXPOSURE**

If claim is for Secondary Exposure, *DO NOT* complete Part 4, proceed to Part 5.

Part 4 of this Claim Form must be completed if the Injured Party claims that his/her asbestos-related disease is a direct result of his/her occupational asbestos exposure. **See the TDP for exposure evidence necessary to meet the requirements for a valid and compensable claim. Copy this page if exposure occurred at more than one site.**

4.1 Leslie Controls Asbestos Exposure

Employer: _____ City: _____ State: _____

Site/Location of Alleged Exposure: _____ City: _____ State: _____

Date employment began: ____ / ____ / ____ Date employment ended: ____ / ____ / ____

Profession/Job Description: _____

Describe exposure to Leslie Controls asbestos-containing product: _____

Identify Leslie Controls asbestos-containing product: _____

Medicare Reporting. For Medicare reporting purposes, was the Injured Party exposed on or after December 5, 1980 to asbestos-containing products and/or conduct for which the Injured Party alleges Leslie Controls, Inc. or its predecessors has legal responsibility? Yes No

Attach work history to establish meaningful and credible Leslie Controls Exposure prior to December 31, 1986, and Significant Occupational Exposure (SOE) to asbestos, as applicable.

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4.2 Significant Occupational Exposure (SOE) for Claims other than Mesothelioma Claims.
[Please check all applicable statements.]

Employment for a cumulative period of at least five (5) years with a minimum of two (2) years prior to December 31, 1986 in an industry and an occupation in which the Injured Party:

- Handled raw asbestos fibers on a regular basis;

- Fabricated asbestos-containing products so that the Injured Party in the fabrication process was exposed on a regular basis to raw asbestos fibers;

- Altered, repaired or otherwise worked with an asbestos-containing product such that the Injured Party was exposed on a regular basis to asbestos fibers; or

- Was employed in an industry and occupation such that the Injured Party worked on a regular basis in close proximity to workers engaged in the activities described in the preceding categories.

-Attach Work History- (If Leslie Controls work history exposure does not meet SOE requirements)

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**Part 5: SECONDARY EXPOSURE: EXPOSURE THROUGH
OCCUPATIONALLY EXPOSED PERSON**

Complete this part **only** if the Injured Party's asbestos-related disease is a result of asbestos exposure through an Occupationally Exposed Person ("OEP").¹

Provide the following for each OEP claimed. Copy this page if more than one OEP is claimed.

5.1 Injured Party's Exposure Through OEP

The Injured Party had asbestos exposure on a regular basis through the OEP identified in 5.2 below

From: ____ / ____ / ____ To: ____ / ____ / ____

Injured Party's Relationship to OEP: _____

Describe the Injured Party's asbestos exposure through the OEP that is alleged to be the cause of the Injured Party's asbestos-related disease:

Medicare Reporting. For Medicare reporting purposes, was the Injured Party exposed on or after December 5, 1980 to asbestos-containing products and/or conduct for which the Injured Party alleges Leslie Controls, Inc. or its predecessors has legal responsibility? Yes No

5.2 OEP's Leslie Controls Asbestos Exposure [Copy this page if exposure occurred at more than one site.]

Name of OEP: _____
 [First Name] [Middle Name] [Last Name]

Employer: _____ City: _____ State: _____

Site/Location of Alleged Exposure: _____ City: _____ State: _____

Date employment began: ____ / ____ / ____ Date employment ended: ____ / ____ / ____

Profession/Job Description: _____

Describe exposure to Leslie Controls asbestos-containing product: _____

¹ If the Injured Party claims direct occupational exposure to asbestos as well as exposure to an OEP, complete Part 4: LESLIE CONTROLS SPECIFIC OCCUPATIONAL EXPOSURE AND SIGNIFICANT OCCUPATIONAL EXPOSURE and Part 5: SECONDARY EXPOSURE: EXPOSURE THROUGH OCCUPATIONALLY EXPOSED PERSON.

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Identify Leslie Controls asbestos-containing product: _____

Attach work history for the OEP to establish meaningful and credible Leslie Controls Exposure, prior to December 31, 1986, and Significant Occupational Exposure to asbestos, as applicable.

5.3 OEP's Significant Occupational Exposure for Claims other than Mesothelioma Claims.

[Please check all applicable statements.]

Employment for a cumulative period of at least five (5) years with a minimum of two (2) years prior to December 31, 1986 in an industry and an occupation in which the OEP:

- Handled raw asbestos fibers on a regular basis;
- Fabricated asbestos-containing products so that the OEP in the fabrication process was exposed on a regular basis to raw asbestos fibers;
- Altered, repaired or otherwise worked with an asbestos-containing product such that the OEP was exposed on a regular basis to asbestos fibers; or
- Was employed in an industry and occupation such that the OEP worked on a regular basis in close proximity to workers engaged in the activities described in the preceding categories.

-Attach Work History- (If Leslie Controls work history exposure does not meet SOE requirements)

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Part 6: PROOF OF EXPOSURE

Proof of exposure may be demonstrated by:

The Injured Party or Official Representative may complete **Part 8: CERTIFICATION** of this claim form and check the box certifying that he or she is acting on personal knowledge, in which case the claim form shall serve as an Affidavit or Sworn Statement.

OR

The Attorney or Official Representative may complete **Part 8: CERTIFICATION** of this claim form and provide an affidavit or sworn statement on personal knowledge of a co-worker or of a family member in the case of a deceased claimant (provided the Trust finds such evidence reasonably reliable).

AND

For Leslie Powerhouse and Below-Deck Naval Station Claims, the following documentation also must be provided:

- Proof of military service or employer;
- Evidence of location of military service or employment;
- Satisfactory evidence of trade or job, such as employment application, invoices or employment, construction, military, union or similar records; and
- If the exposure is alleged to have occurred on a commercial vessel, independent corroborating documentary evidence of Leslie asbestos-containing products.

In addition, one or more of the following documents may be submitted to supplement credibility as to proof of exposure.

- Verified Listing of employer/jobsites
- Verified Work History
- Answers to Claimant Interrogatories with verification page
- Deposition Transcript with cover page(s)

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Part 7: INDIVIDUAL REVIEW INFORMATION

Complete this part only if Individual Review is elected.

7.1 Smoking History

<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date -- / -- / --	End Date -- / -- / --	Per Day (packs, cigars, pipes)
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date -- / -- / --	End Date -- / -- / --	Per Day (packs, cigars, pipes)
<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipes	Start Date -- / -- / --	End Date -- / -- / --	Per Day (packs, cigars, pipes)

7.2 Economic Loss

Wage Loss

Employment Status (including Military Service)	Check the box if you have attached an economic loss report containing documentation of the following:	Last annual wage and date employment ceased
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased		\$ _____ ____ / ____ / ____

Other Economic loss

Other Sources of Income and Living Expenses	Check the box if you have attached an economic loss report containing documentation of the following:
<input type="checkbox"/> Pension <input type="checkbox"/> Social Security <input type="checkbox"/> Household Services <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Funeral Expenses	

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7.3 Heirs

Last name	First name	Middle name	Date of Birth	Relationship to Injured Party	Financially Dependant
			--/ /----		__ Yes __ No

Last name	First name	Middle name	Date of Birth	Relationship to Injured Party	Financially Dependant
			--/ /----		__ Yes __ No

Last name	First name	Middle name	Date of Birth	Relationship to Injured Party	Financially Dependant
			--/ /----		__ Yes __ No

Last name	First name	Middle name	Date of Birth	Relationship to Injured Party	Financially Dependant
			--/ /----		__ Yes __ No

7.4 Foreign Claim

Check here if the Injured Party was exposed to an asbestos-containing product for which Leslie Controls, Inc. has legal responsibility outside of the United States and its Territories and Possessions and outside the Provinces and Territories of Canada.

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Part 8: CERTIFICATION

This claim is certified by (check one and check capacity in which Certification is provided)

- Injured Party on personal knowledge

- Official Representative
 - on personal knowledge
 - affidavit or sworn statement attached

- Attorney (affidavit or sworn statement attached)

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 in all material respects.

Signature of the Injured Party, Official Representative or Attorney

Printed name