

PRIVATE LIEN RESOLUTION PROGRAM OFFER AND ACCEPTANCE

A. PARTICIPATING CLAIMANT INFORMATION

I have read and understand the document titled “*Guidant Private Lien Resolution Program Claimant Information*” which explains the offer of the Private Lien Resolution Program. Having been fully informed of the offer, I elect to participate in the Private Lien Resolution Program according to the terms and conditions outlined in that document.

Name	<small>Last</small>	<small>First</small>	<small>Middle</small>
SSN**	- -	**Important**	Claim #**
Signature	**Important**	Date	____/____/____ <small>(month) (day) (year)</small>

NAME AND SSN OF INJURED INDIVIDUAL IF NOT THE SAME AS THE SIGNING PARTY:

Name	<small>Last</small>	<small>First</small>	<small>Middle</small>	SSN	- -
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Check the appropriate box that applies to you (check only one):

- I am an adult claiming Guidant-related injuries and signing for myself.
- I am the Parent or Legal Representative of a disabled adult or a minor who claims Guidant-related injuries.
- I am the Authorized Representative of a deceased individual who was injured by Guidant.

B. PRIVATE HEALTH INSURANCE COVERAGE

Provide the following additional information. Identify each of the Non-governmental healthcare providers or insurers that you believe may have paid in any way for care related to your Guidant-related injuries since the first date of your Guidant event through December 2007. Be as specific as possible. If you have a copy of the applicable health insurance card, enclose a copy of that card as well.

B.1. Private Health Insurance

Plan Name		Plan ID #		Employer Name	
Plan Name		Plan ID #		Employer Name	

B.2. Medicare Advantage Plan through a Private Insurer Rather Than Through the Federal Government

Plan Name		Plan ID #		Employer Name	
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B.3. MediGap or Medicare Supplemental Insurance Through a Private Insurer Rather Than the Federal Government

Plan Name		Plan ID #		Employer Name	
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B.4. Other

Plan Name		Plan ID #		Employer Name	
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If you have received correspondence from a Private Health Insurance Provider(s) inquiring about your Guidant settlement, attach copies of the correspondence and return them with this questionnaire.

C. RETURNING THIS FORM

Please return this Form and the “Authorization to Disclose Health Information Form” and any enclosures by the 7/31/09 deadline to:

<< Insert Counsel Address Here >>